United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Remote Virtual Review: September 13-16, 2021

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Background

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

In 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.

In addition, the parties set forth 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.

For this review, this report summarizes the findings of the two Independent Monitors, each of whom have 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 Center'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 review, the Monitoring Teams requested various types of information about the individuals who lived at the Center 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 Center's compliance with all provisions of the Settlement Agreement.

b. **Onsite review** – Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the onsite review portion of this review was not conducted. Instead, the Monitoring Teams attended various meetings via telephone, such as Center-wide meetings [e.g., morning medical, unit morning, Incident Management Review Team (IMRT), Physical and Nutritional Management Team (PNMT)], and individual-related meetings [e.g., Individual Support Plan meetings (ISPs), Core teams, Individual Support Plan addenda meetings (ISPAs), psychiatry clinics]. In addition, the Monitoring Teams conducted interviews of various staff members via telephone (e.g., Center Director, Medical Director, Habilitation Therapies Director, Behavioral Health Services Director, Chief Nurse Executive, Lead Psychiatrist, QIDP Coordinator). Also, the Monitoring Teams met with some groups of staff via telephone (e.g., Psychiatry Department, Behavioral Health Services Department). This process is referred to as a remote review.
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 Center-wide documents. During the week of the remote review, the Monitoring Team requested and reviewed additional documents.
d. **Observations** – Due to the nature of the remote review, the Monitoring Team could not complete some observations (i.e., as discussed above, some observations of meetings were possible). As a result, some indicators could not be monitored or scored. This is noted in the report below.
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 move to the category of requiring less oversight. At the next review, indicators that move to this category will not be monitored, but may be monitored at future reviews if the Monitor has concerns about the Center'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 Center'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 Center'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. 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.
g. **Quality improvement/quality assurance:** The Monitors' report regarding the monitoring of the Center's quality improvement and quality assurance program is provided in a separate document.

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.

Staffing. About 50% of the DSP positions were vacant. As a result, the Center prioritized ensuring minimum staffing ratios were being met. To that end, management, professional, clinical, and support staff were themselves working direct care about 16 hours per month. State Office and the Center were working on strategies to improve recruitment success, retention, and support for the current set of DSPs (e.g., frequent communication).

Aggression between individuals. For many years, the Center addressed the occurrence of aggression between individuals (also known as peer to peer aggression). The number of occurrences remained high, probably due to a combination of the complex clinical presentations of the individuals and the shortage in DSPs. All individuals in the ISP review group had been the victim of peer-to-peer aggression on numerous occasions, with several incidents resulting in injuries. Center management said they would be re-instituting a work group to address this issue.

Pharmacy: Based on the Center's scores over the previous three monitoring cycles, the Center has achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions, and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that will be measured through Section J.12. With the understanding that these topics are covered elsewhere in the Settlement Agreement, San Angelo SSLC will exit from the other requirements of Section N of the Settlement Agreement.

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 remote review. The Center 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, and their time and efforts are much appreciated.

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 contains 17 outcomes and 42 underlying indicators in the areas of restraint management; abuse, neglect and incident management; pretreatment sedation/chemical restraint; mortality review; and quality assurance. Sixteen of these indicators were in the category of requiring less oversight. As of this review, an additional two indicators will be moved to this category. They are in the areas of incident management and QA DUEs.

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

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

Restraint

The Center showed sustained substantial compliance with many of the requirements of Section C of the Settlement Agreement. The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects. With the understanding that these topics are covered elsewhere in the Settlement Agreement, the SSLC exited from the other requirements of Section C of the Settlement Agreement.

For two of the five restraints reviewed, nurses performed physical assessments, documented whether individuals sustained any restraint-related injuries or other negative health effects, and took necessary action. It was also positive that for all of the restraints reviewed, nurses initiated assessments in a timely manner. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: assessing and documenting respiratory rates, even when individuals refuse other vital sign assessments, and following nursing guidelines when assessing injuries, including providing complete descriptions with measurements.

Abuse, Neglect, and Incident Management

The IMC and the IM department were knowledgeable about investigation processes and various details about each investigation.

Most monitoring indicators maintained high performance from previous reviews.

Timely completion of HHSC PI investigations remained below criteria. Some facility investigations also were not completed timely. In most cases, the high volume of allegations, staffing challenges and turnover at HHSC PI, and pandemic limitations were contributory factors.

The Monitoring Team attended the quarterly meeting with HHSC PI, OIG, and the Center. There was good discussion and participation.

Other
Pretreatment sedation was used for one individual in the review group. The requirements for IDT review were not met.

It was good to see that the Center completed clinically significant drug utilization evaluations (DUEs). Given the Center's performance during this review and the last two reviews, this indicator will move to the category requiring less oversight.

Restraint

At a previous review, the Monitor found that that the Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement.

The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects (immediately below).

With the understanding that these topics are covered elsewhere in the Settlement Agreement, the SSLC exited from the other requirements of Section C of the Settlement Agreement.

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.	
Summary: For two of the five restraints reviewed, nurses performed physical assessments, documented whether individuals sustained any restraint-related injuries or other negative health effects, and took necessary action. It was also	Individuals:

positive that for all of the restraints reviewed, nurses initiated assessments in a timely manner. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: assessing and documenting respiratory rates, even when individuals refuse other vital sign assessments, and following nursing guidelines when assessing injuries, including providing complete descriptions with measurements. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	410	450	471	495	247				
a.	If the individual is restrained using physical or chemical restraint, nursing assessments (physical assessments) are performed in alignment with applicable nursing guidelines and in accordance with the individual's needs.	40% 2/5	1/1	1/1	0/1	0/1	0/1				
b.	If the individual is restrained using PMR-SIB:										
	i. A PCP Order, updated within the last 30 days, requires the use of PMR due to imminent danger related to the individual's SIB.	N/A									
	ii. An IHCP addressing the PMR-SIB identifies specific nursing interventions in alignment with the applicable nursing guideline, and the individual's needs.	N/A									
	iii. Once per shift, a nursing staff completes a check of the device, and documents the information in IRIS, including: a. Condition of device; and b. Proper use of the device.	N/A									
	iv. Once per shift, a nursing staff documents the individual's medical status in alignment with applicable nursing guidelines and the individual's needs, and documents the information in IRIS, including: a. A full set of vital signs, including SPO2; b. Assessment of pain; c. Assessment of behavior/mental status; d. Assessment for injury; e. Assessment of circulation; and f. Assessment of skin condition.	N/A									
c.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	60% 3/5	1/1	1/1	0/1	0/1	1/1				

d.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	50% 2/4	1/1	1/1	0/1	0/1	N/A				

Comments: The restraints reviewed included those for: Individual #410 on 7/8/21 at 8:20 p.m. (i.e., side-lying horizontal for seven minutes), Individual #450 on 4/20/21 at 10:27 a.m. (chemical), Individual #471 on 7/29/21 at 3:06 p.m. (chemical), Individual #495 on 7/13/21 at 9:50 p.m. (cross-arm stabilization multi-person for 21 minutes), and Individual #247 on 5/7/21 at 3:45 a.m. (cross-arm stabilization for two minutes).

a., c., and d. For Individual #410 on 7/8/21 at 8:20 p.m. (i.e., side-lying horizontal for seven minutes), and Individual #450 on 4/20/21 at 10:27 a.m. (chemical), the nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed.

The following provide examples of additional findings:

- It was positive that for all of the restraints reviewed, nurses initiated assessments in a timely manner.
- It was also positive that for four of the five restraints reviewed, nurses monitored and documented the necessary details about the individuals' mental status. The exception was for Individual #471's chemical on 7/29/21. Following the administration of the chemical restraint, nursing staff did not follow the applicable nursing guidelines. For example, the individual reportedly refused vital sign assessments, but the nurses did not document the individuals' respiratory rate, which does not require the individual's cooperation. Based on documentation submitted, nursing staff also did not complete necessary assessments (e.g., respiratory rate, pulse, or blood pressure) after the individual calmed down. Evidence also was not found to show that nurses completed an assessment to determine whether or not the individual sustained injuries.
- For Individual #495's restraint on 7/13/21 at 9:50 p.m., nursing staff documented his temperature, pulse, blood pressure, and oxygen saturation. No respiratory rate was documented. According to the documentation, the individual said that an injury to his left hand from restraints the previous day was worse after the most recent restraints. Neither the IPNs nor the injury report provided a description of the injury, such as the color or measurements, which are necessary to monitor if it was resolving or worsening.
- For Individual #247's restraint on 5/7/21 at 3:45 a.m., the follow-up nursing assessment at 4:36 a.m. indicated that the individual refused vital sign assessments, but the nurse did not document a respiratory rate, which does not require the individual's cooperation.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.												
Summary:			Individuals:									
#	Indicator	Overall Score										
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.													
Summary:			Individuals:										
#	Indicator	Overall 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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.											
Comments:													

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.													
Summary:			Individuals:										
#	Indicator	Overall Score											
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.											
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.												
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.												
Comments:													

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.													
Summary:			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: This indicator has been in the category of requiring less oversight since round 11 and it will remain in that category. That being said, HHSC PI noted in their quarterly meeting minutes 6/9/21 that they were having difficulties completing staff interviews partly because staff were not returning phone calls. Moreover, most HHSC PI investigations were completed far beyond the 10 day requirement. It is possible that staffing challenges at HHSC PI, staffing challenges at the Center, and COVID precautions competed with investigation completion and/or with staff availability for interviews. Neither of these reasons, however, was noted in the PI reports or in the UIRs. A long period of time between the allegation and the staff interview threatens the confidence the investigator (and reviewer) can have in the interview testimony. It was evident to the Monitoring Team that the Center's administration and incident management department, HHSC PI, and OIG were working hard to resolve the delay in investigation completion.			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:			Individuals:									
#	Indicator	Overall Score										
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.											
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)											
Comments:												

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: See comments below. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	413	450	300	201	412	376			
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/QA specialist (unless a written extension documenting extraordinary circumstances was approved in writing).	17% 2/12	0/3	0/2	1/3	0/1	1/2	0/1			
13	There was evidence that the supervisor/QA specialist 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.	45% 5/11	1/3	0/2	2/3	0/1	1/1	1/1			

Comments:

12. There were nine HHSC PI investigations in the review group. Two were completed timely; both were administrative referrals. Completion duration for the other eight ranged from 17 days to 67 days. There had been extensive completion times for San Angelo SSLC's HHSC PI investigations for a number of years. The causes were multiple, but primarily were staffing shortages at HHSC PI investigation unit, staffing shortages at the Center (making it sometimes difficult for investigators to find time to conduct interviews), the high number of allegations at the Center (many due to individuals making false allegations), and adjustments in protocols due to COVID 19.

Extension requests were submitted as required by HHSC PI. The reasons were related to staffing resource challenges.

Many activities were occurring to correct this. For instance, the Center was in contact every day with HHSC PI about the status of investigations, State Office was in contact with the Center most every day, State Office tracked daily and monthly data (and provided a monthly report to the Monitor), the Center Director documented her review of every extension request to determine if additional protections were in order for the individuals, Center management met regularly to support those DSPs who were on no contact status due to the allegation. In addition, a regular meeting occurred between the Center, HHSC PI, and OIG to talk about any issues with investigations, in particular, investigation completion. The Monitoring Team attended this meeting during the review week and observed meaningful conversation and problem solving.

There were three Center-only investigations. All three were also completed in more than 10 days; also due to staffing challenges and high workload within the Center's incident management department.

To summarize, the Center, State Office, and HHSC PI were well aware of the problem and working to fix it and improve it.

13. Investigation review was complete and met criteria for two of the HHSC PI investigations and for all three Center-only investigations. One investigation's review was not yet completed. For the other six HHSC PI investigations, the investigation review findings were that the investigation was completed timely when it wasn't (see comments above for indicator 12).

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: Indicator 15 will be moved to the category of requiring less oversight due to sustained high performance.			Individuals:								
#	Indicator	Overall Score	413	450	300	201	412	376			
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.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

Comments:

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

Summary:			Individuals:								
#	Indicator	Overall Score									
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:

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.

Summary: This outcome consists of one facility indicator.			Individuals:								
#	Indicator	Overall Score									

19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.
20	Over the past two quarters, the facility's trend analyses contained the required content.	Monitoring of the Center's quality improvement program is now presented in the separate document "Monitoring Team Report for Quality Improvement Review."
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: N/A			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	N/A									
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. and b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals in the physical health review group received dental pre-treatment sedation.											

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. On 4/8/21, Individual #189 received oral pre-treatment sedation for an off-campus appointment for a magnetic resonance (MRI) test. Center staff did not submit evidence that the PCP sought input from the IDT, when determining the medication and dosage range. They also did not submit evidence of informed consent for the pre-treatment sedation. It was positive that nursing staff documented pre- and post-procedure vital signs.

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: PTS was used for one individual in the review group. The requirements for IDT review were not met. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 413	376	383	300	450	201	412	471	189
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:

1. Individual #189 had pretreatment sedation for an MRI on 4/8/21. Available records did not discuss PTS usage and effectiveness during the past 12 months, or include informed consent

2. There was no evidence that the IDT developed an action plan to reduce the usage of PTS, or determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.

3-6. No treatments or strategies were developed to minimize or eliminate the need for PTS.

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	77								
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.	0% 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% 0/1	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% 0/1	0/1								
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/1	0/1								
e.	Recommendations are followed through to closure.	0% 0/1	0/1								

Comments: a. Since the last document submission, two individuals died. The Monitoring Team reviewed one of the deaths. Due to the recency of the second death, complete information was not yet available. Causes of death were listed as:

- On 2/6/21, Individual #77 died at the age of 45 with causes of death listed as cardiopulmonary arrest, acute on chronic hypoxic respiratory failure, and COVID-19 pneumonia. For this death, the Center submitted an unsigned clinical death review committee report, so the Monitoring Team could not assess its timeliness.
- On 8/8/21, Individual #294 died at the age of 74 with preliminary cause of death listed as progressively increasing intracranial pressure due to herniating mass.

b. through d. The Center completed death reviews for Individual #77. This resulted in the identification of some concerns, and related recommendations. For example, the Nursing Clinical Death Review identified concerns related to the acute care planning and implementation process. More specifically, the reviewer identified that an RN had not reviewed acute care plans within the specified timeframes to ensure they included the necessary interventions, and nurses had not consistently implemented the interventions. The latter resulted in a recommendation to retrain nursing staff on implementation of acute care plans.

However, evidence was not submitted to show the Center staff conducted thorough reviews of the care and treatment provided to the individual, or an analysis of the mortality reviews to determine additional steps that should be incorporated into 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. For example, for Individual #77:

- The Center submitted a Clinical Death Review by Medical Services that was not signed. Therefore, it was unclear who completed the review. The Review provided excerpts from the records in which the writer referred to himself/herself as "I." A physician who has completed training in primary care medicine should complete the Medical Reviews.
- The Medical Review documented that the individual had Stage 4 chronic kidney disease (CKD) secondary to bilateral hydronephrosis, poorly controlled Type 2 diabetes mellitus (T2DM), and hypertension. The review provided no clear information on how well her hypertension was controlled. It also did not document the level of control of her T2DM at the time of illness.
- The review noted that the individual had an incomplete audiology exam. The mortality review process resulted in no corresponding recommendation. As the Monitoring Team's findings in this report show, several of the individuals in the review group had incomplete or deficient audiology evaluations as well. The Center needs to determine the cause of this recurrent gap in care.
- The medical reviewer did not document whether or not the individual received the COVID-19 vaccination. It was not clear if vaccinations were available at the Center in January 2021. High risk individuals residing in long-term care facilities were given priority to receive the vaccine. The individual was at risk for progression to severe disease, but the Medical Review did not discuss whether or not monoclonal antibodies were available at the Center in mid-January. Monoclonal antibodies were approved for use under the Emergency Use Authorization (EUA) at the time of her diagnosis.
- The Clinical Death Review did not discuss the reasons for the following recommendations:
    - Train primary care providers (PCPs) on importance of recurrent urinary tract infections (UTIs) in CKD;
    - Train PCPs on the management of recurrent UTIs in women;
    - Research and establish a Weight Management Committee; and
    - Implement a smoking cessation course and PCP involvement through AMA documentation/recommendations.
- In the Nursing Clinical Death Review, the reviewer did not answer some important question, for example, about the quality of the Integrated Risk Rating Form (IRRF), and medication administration. The reason given was that the individual was hospitalized prior to her death. In answering these questions, the reviewer should have reviewed the time period prior to the individual's hospitalization.

e. Some improvement was noted with regard to the mortality committee writing recommendations in a way that ensured that Center practice improved. For example, a recommendation that read: "ACP training – interventions not followed as written in care plan" resulted in an in-service training. The Administrative Death Review Committee also appropriately required weekly audits to determine whether nurses implemented interventions as written.

However, other recommendations did not follow this format. For example, another recommendation was for the Medical Department to "Train PCPs on management of recurrent UTI in women by reviewing the following article…." The Committee listed the evidence as a training roster. This did not ensure that practices changed. The recommendation should have been written in a manner that required auditing/follow-up to determine whether or not medical staff made needed changes to their practices.

The Center's chart indicated that for two of seven recommendations related to Individual #77's death were still either "in process," or "nothing reported."

The documentation the Center provided made it difficult to determine whether or not, and when a Clinical death review recommendation was completed. Center staff often provided raw data as evidence of implementation. For example, staff training rosters were included, but Center staff did not include information about how many staff required training. As a result, this documentation could not be used to determine whether or not staff fully implemented the recommendation. Staff should summarize data, including, for example, the number of staff trained (n), in comparison with the number of staff who required training (N).

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	189	412	137	203	410	247	429	319	343
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.

As discussed in the Monitoring Team's previous reports on the Center's QA/QI system, it is essential Center implement reliability probes/checks to determine whether or not data are reliable. These would include mechanisms to ensure that potential ADRs are reported (e.g., comparing lists of medications prescribed for allergic reactions to the list of ADRs reported, etc.). In addition, guidelines such as those that the American Society of Hospital Pharmacists (ASHP) publishes provide direction in terms of ensuring full reporting.

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: Given that during the last two review periods and during this review, the Center completed clinically significant DUEs (Round 15 – 100%, Round 16 – 100%, and Round 17 – 100%), Indicator a will move to the category of requiring less oversight. Indicator b will remain in active monitoring.		
#	Indicator	Score

a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	
Comments: a. and b. In the six months prior to the review, San Angelo SSLC completed two DUEs, including: • A DUE on angiotensin converting enzyme inhibitors/angiotensin-receptor blockers (ACEI/ARBs) and lithium toxicity that was presented to the Pharmacy and Therapeutics (P&T) Committee on 6/24/21, for which follow-up was completed; and • A DUE on clozapine use and neutropenia that was presented to the P&T Committee on 3/18/21, for which follow-up was completed.		

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, 31 of these indicators were already in, or were moved to, the category of requiring less oversight. For this review, four other indicators were moved to this category, in ISPs, communication, and skill acquisition.

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

Assessments

It was good to see that staff were knowledgeable about the individuals they supported. For the most part, QIDPs were knowledgeable regarding preferences, needed supports, and the status of supports.

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 and update the IRRFs within no more than five days.

It was positive that for the nine individuals in the review group, PCPs completed timely annual medical assessments (AMAs). Center staff should continue to improve the quality of the medical assessments, particularly with regard to, as applicable to the individual, family history, past medical histories, and thorough plans of care for each active medical problem, when appropriate.

For seven of the nine individuals in the review group, PCPs also completed timely interval medical reviews (IMRs). The quality of these needs improvement.

Overall, the lack of a dentist at the Center or alternative arrangements for the provision of general dentistry services negatively impacted the provision of timely dental examinations, although some progress was noted with regard to the quality of dental examinations. Annual dental summaries were often not timely and were often based on outdated dental examinations. As a result, IDTs did not have access to information about individuals' existing dental needs.

For four out of six individuals reviewed, nurses completed timely quarterly nursing record reviews and physical assessments. For the remaining two individuals, nurses relied on physical assessments that were completed between a month and six weeks before the record reviews. This resulted in the quarterly reviews including out-of-date, and potentially inaccurate information.

It was positive that for more than half of the risk areas reviewed, nurses included status updates in annual record reviews, and for more than 80% of the risks reviewed, the quarterly record reviews included relevant clinical data. Work is needed, though, for Registered Nurse Case Managers (RNCMs) to analyze this information, and offer relevant recommendations. Improvement continued with the content and thoroughness of other portions of the record reviews, as well as the annual and quarterly physical assessments.

For 40% of the exacerbations of individuals' chronic conditions that the Monitoring Team reviewed, nurses completed assessments in accordance with current nursing guidelines.

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. Similar to the last review, Center staff should focus on improving referral of all individuals that meet criteria for PNMT review, timely completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, as well as the quality of the PNMT comprehensive assessments.

The Center made progress in providing occupational therapy/physical therapy (OT/PT) assessments that were both timely and of the correct type in accordance with individuals' needs. The quality of OT/PT assessments continues to be an area on which Center staff should focus.

It was positive that, as applicable, Center staff provided timely communication assessments that were also of the type in accordance with individuals' needs. Two related indicators will move to the category requiring less oversight. The Center still needed to focus on improving the quality of communication assessments in order to ensure that speech language pathologists (SLPs) provide IDTs with clear understandings of individuals' functional communication status; augmentative and alternative (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.

The identification of individualized, practical, and functional SAPs continued to be a challenge for San Angelo SSLC, however, there was good quality discussion about SAPs during the annual ISP and ISP preparation meetings observed during the review week.

Two-thirds of individuals had a current FSA ad/or vocational assessment. These assessments were made available to the IDT before the ISP meeting and almost all of them included recommendations for skill acquisition.

Several SAPs were judged to be unmeasurable due to objectives that specified multiple prompts (e.g., two verbal prompts) because the data system could not measure the frequency of prompts used.

Individualized Support Plans

In the ISPs, for five of the six individuals, personal goals met criteria in from three to five areas for a total of 20 goals that met criteria. Overall, this was about the same as at the last review. More work is needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks

In the ISPs, about two-thirds of goals were written in measurable terminology. About one-quarter of the goals that met criteria with indicator 1 had a good set of action plans to support achievement of the goal. For the most part, action plans were simple statements, lacking specific implementation strategies, supports needed, and criteria for documenting and assessing progress.

Many action plans were not implemented and revisions were not made. Thus, individuals did not meet any goals and very few were showing progress.

Teams met often to review incidents and make recommendations to address risks. Even so, it was not evident that IDTs were tracking the implementation and outcome of these recommendations.

Team participation was good for annual ISP meetings. Annual ISP meetings were observed for two individuals. It was good to see that both individuals were encouraged to participate in their meetings and had input into goals for the upcoming year. It was particularly nice to see that one individual's IDT rearranged the meeting agenda order to encourage her participation in areas that were important to her.

The psychiatry department was identifying indicators for reduction and in some cases for increase. The psychiatry clinicians need to ensure that the relationship of the indicator to the individual's diagnosis is clearly designated and that indicators are consistently identified. The psychiatric clinicians were regularly defining the indicators and writing goals associated with at least one indicator. The goals were not entered into the facility's overall treatment program, the IHCP.

It was good to see psychiatrist attendance at ISP meetings. Psychiatry ISP-related documentation needed improvement

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

The seven Physical and Nutritional Plans (PNMPs)/Dining Plans reviewed met the requirements for quality. Given that during the previous review, the Center's score was 63%, and problems noted during that review were minimal, if the Center sustains its progress overall, then, after the next review, the related indicator might move to the category requiring less oversight.

ISPs

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

Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas, however, one individual's goals met criteria for all five personal goal areas. Moreover, across the six individuals, personal goals met criteria in from three to five areas for a total of 20 goals that met criteria. Overall, this was about the same as at the last review. More work is needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.

The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health and wellness goals. The Monitoring Team looks at two health and wellness areas that rated as being at medium or high risk (in the IRRF) plus a dental goal if that area is rated as being at medium or high risk, plus suction toothbrushing if the individual receives suction toothbrushing.

Indicator 2 shows performance regarding the writing of goals in measurable terminology. For two of the individuals, all of their goals that met criteria with indicator 1 were written in measurable terminology. Overall, about two-thirds of goals were written in measurable terminology. Indicator 3 shows that about one-quarter of the goals that met criteria with indicator 1 had a good set of action plans to support achievement of the goal. These three indicators will remain in active monitoring.

Individuals:

#	Indicator		Overall Score	413	450	412	189	429	410			
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.	Personal goals	17% 1/6 67% 20/30	4/5	5/5	4/5	0/5	3/5	4/5			
		Health goals	0% 0/6 0% 0/15	0/2	0/3	0/2	0/3	0/2	0/3			

2	The personal goals are measurable.	Personal goals	33% 2/6 68% 13/20 50% 15/30	3/4 4/5	1/5 1/5	2/4 2/5	-/- 1/5	3/3 3/5	4/4 4/5			
		Health goals	0% 0/6 --% -/- 0% 0/15	0/2	0/3	0/2	0/3	0/2	0/3			
3	ISP action plans support achieving the individual's personal goals.		0% 0/6 25% 5/20	1/4	3/5	0/4	-/-	0/3	1/4			

Comments: The Monitoring Team reviewed the ISP process for six individuals at the San Angelo State Supported Living Center: Individual #412, Individual #189, Individual #413, Individual #450, Individual #429, and Individual #410. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs and QIDPs, and directly remotely observed individuals at the San Angelo SSLC facility.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 19 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and based on input from individuals on what was important to them. For this review, 20 goals met this criterion. The personal goals that met criterion were:

- the leisure goal for Individual #412, Individual #413, Individual #450, Individual #429, and Individual #410.
- the relationship goal for Individual #412, Individual #413, Individual #450, Individual #429, and Individual #410
- the work/day/school goal for Individual #413, Individual #450, and Individual #410.
- the independence goal for Individual #412 and Individual #450.
- the living options goal for Individual #412, Individual #413, Individual #450, Individual #429, and Individual #410.

Some goals did not meet criterion for the indicator because they did not reflect the individual's specific preferences, strengths, and needs or did not provide opportunities to try new activities and learn new skills. For instance:

- Individual #189 had a relationship goal to participate in two community outings of his choice and live at San Angelo SSLC. His IDT agreed to meet within 45 days of his ISP to gather more information on his preferences and develop additional goals. His ISP was developed in January 2021. There was no evidence that his IDT had met to develop goals.
- Individual #412 had a work/day goal to work at the greenhouse feeding chickens. She indicated that she wanted to work at Dairy Queen cleaning tables or at Dollar General in the community. Her vocational assessment noted that she preferred to

work indoors and preferred tasks where she could sit and work. At the time of her assessments, she expressed interest in feeding chickens at the greenhouse. QIDP monthly reviews indicated that she was never assessed for this job and lost interest. Her goal was not revised until her ISP meeting for the following year. She again told her team that she wanted a job in the community.

- Individual #413 had a greater independence goal to cook for her friends. Documentation indicated that Individual #413 was able to cook independently and routinely cooked for her peers. Assessments completed months after her ISP meeting also indicated that she was able to cook independently.
- Individual #429 had a greater independence goal to manage her cigarettes daily. This appeared to be a compliance related goal since documentation indicated that she could independently manage her cigarettes. Her ISP did not include a work/day goal. Her assessments indicated that she did not like the jobs offered on campus and routinely refused to work. She stated that she wanted to work at a restaurant in the community. Her vocational assessment indicated that she would have opportunities to gain skills needed to work in the community at the work center on campus. The IDT did not identify what job training would be offered.
- Individual #410's greater independence goal was to have routine LOS to be independent in his work/social interactions away from the home. This goal did not identify specific skills for training or state what the individual would have to do to achieve the goal.
- None of the individuals had goals to support their participation in improving or maintaining their own health and wellness. There were goals related to clinical outcomes (e.g., medical, nursing, dental, such as to lose two pounds per month, or to maintain an A1c of less than 7; see bulleted list below), but none related to actions in which the individual might engage.
    - Individual #412: weight and gastrointestinal issues
    - Individual #189: dental, cardiac issues, and osteoporosis, falls, and fractures
    - Individual #413: weight and metabolic syndrome/diabetes
    - Individual #450: dental, weight, and polypharmacy
    - Individual #429: respiratory issues and weight
    - Individual #410: dental, choking, and cardiac issues

In some cases, it was difficult to determine if goals were individualized and/or aspirational because assessments were not completed prior to goal implementation to determine if the individual was interested in the activity or needed training in that area. Consequently, some goals were discontinued due to lack of interest or implementation during the ISP year.

2. Of the 20 personal goals that met criterion for indicator 1, 13 also met criterion for measurability. Two others that did not meet criteria for indicator 1 were measurable. Those that were measurable:

- Recreation/Leisure: Individual #413, Individual #429, and Individual #410
- Relationship: Individual #412, Individual #429, and Individual #410
- Job/School/Day: Individual #413 and Individual #410
- Greater Independence: Individual #413
- Living Option: all six

For goals that were not measurable, the goal was not written in observable, measurable terms, did not indicate what the individual was expected to do, or how many times they were expected to complete tasks/activities. Those included:

- Recreation/leisure: Individual #412, Individual #189, and Individual #450
- Relationship: Individual #189, Individual #413, and Individual #450
- Job/School/Day: Individual #412, Individual #189, Individual #450, and Individual #429
- Greater Independence: Individual #412, Individual #189, Individual #450, Individual #429, and Individual #410
- Health and Safety: Individual #412, Individual #189, Individual #429, and Individual #410

3. For the 20 goals that met criterion for being personal and individualized, five had corresponding action plans that were supportive of goal-achievement. Action plans to support goals should include all necessary steps; be individualized; integrate strategies to reduce risk, incorporate needs included in ancillary plans; offer opportunities to make choices and decisions, where relevant; and support opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals. Goals that had action plans that were likely to lead to achievement of goals were:

- Individual #450's recreation/leisure, work/day, and relationship goals.
- Individual #413's relationship goal.
- Individual #410's relationship goal.

Examples of goals that did not meet criteria:

- Individual #410's work/day goal to work in his family's taco truck was individualized and based on his preferences. Action plans to support his goal did not describe supports and training needed and were unlikely to lead towards achievement of his goal. Action plans included:
  - will apply to minimum wage on campus.
  - will be assessed for cooking program.
  - will decrease his level of supervision to routine
  - will maintain 75% attendance to work each month.
  - will receive token slips for attendance to both sessions and work. Individual #410 will be assessed on customer service skills.
  - will not display more than 3 instances of property destruction per month for 12 consecutive months in all settings and conditions.
- Individual #413's work/day goal was to independently build a wood project from start to finish and sell the item at a market. Her action plans did not identify what training she would need to master her goal. Action plans included:
  - will have observation checks when she returns from work to maintain employment at the woodshop
  - will increase her attendance to 50% at the work center/wood room
- Individual #412's relationship goal was to have three supervised day visits with her family at a restaurant near Ira, TX. Action plans did not include training or supports needed to achieve her goal. Action plans included:
  - will have 6 successful on-campus, supervised visits.
  - will have 5 successful off-campus, supervised visits, in San Angelo, Tx for 1-2 hours.
  - will have 4 successful off-campus, supervised visits, in San Angelo, Tx for 2-3 hours.
  - will have 3 successful off-campus, supervised visits, in Ira Tx for 1-2 hours.

- will have 3 successful off-campus, supervised visits, in Ira Tx for 2-3 hours.
- will be enrolled in healthy relationships training through Sessions per ISP discussion.
- will attend Sessions classes at least 75%.

- Individual #450's living option goal was to live in a group home in San Angelo, TX. This goal was aspirational and based on her preferences. Action plans were unlikely to lead towards achievement of her goal.
  - will display no more than 1 incidents of physical aggression per month for 3 out of 4 months in all settings and conditions.
  - will display no more than 0 incidents of verbal aggression per month for 3 out of 4 months in all settings and conditions.
  - will display no more than 0 incidents of property destruction per month for 3 out of 4 months in all settings and conditions.
  - will display no more than 0 incidents of self-injurious behavior per month for 3 out of 4 months in all settings and conditions.
  - will display no more than 0 incidents of unauthorized departure per month for 3 out of 4 months in all settings and conditions.
  - will display no more than 0 incidents of inappropriate social behavior per month for 3 out of 4 months in all settings and conditions.
  - A functional assessment will be completed within 90 days of admission and a PBSP will be developed based on the results of that assessment.

Outcome 2: The individual's ISP set forth a plan to achieve goals.

Summary: For the most part, action plans were simple statements, lacking specific implementation strategies, supports needed, and criteria for documenting and assessing progress. For those goals that met criteria with indicators 1 and 2, more than half had documentation. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	413	450	412	189	429	410			
4	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/3 0% 0/5	0/1	0/3	-/-	-/-	-/-	0/1			
5	There is documentation (e.g., data, reports, notes) that is valid and reliable to determine if the individual met, or is making progress towards achieving, each of the personal goals.	17% 1/6 62% 8/13	2/3	0/1	1/2	-/-	3/3	2/4			

Comments:

4. None of the action plans provided sufficient detailed information for implementation, data collection, and review to occur. For the most part, action plans were simple statements, lacking specific implementation strategies, supports needed, and criteria for documenting and assessing progress.

Examples of action plans that did not meet criteria included:

- For Individual #412
  - Will research churches in the community
  - Will have six successful on-campus supervised visits
- For Individual #189
  - Will attend a provider fair in the next year
- For Individual #413
  - Needs to go shopping at least quarterly for her art supplies
  - Will submit her art for local contests/exhibits
- For Individual #429
  - Will maintain hygiene three times a week
  - Will engage in 504A independent program
- For Individual #450
  - Will learn about animal safety
  - Will need to have a decrease in her behaviors before volunteering in the community
- For Individual #410
  - Will obtain an ID
  - Will apply to minimum wage on campus

5. Of the 13 goals that met criteria with indicators 1 and 2, eight had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. QIDPs were doing a better job of summarizing progress/lack of progress towards goals. This included:

- Individual #412: relationship goal
- Individual #413: recreation/leisure and work/day goals
- Individual #429: recreation/leisure, relationship, and living option goals
- Individual #410: recreation/leisure and relationship goals

Outcome 3: All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.												
Summary: Many action plans were not implemented and revisions not made. Thus, individuals did not meet any goals and very few were showing progress. Of the eight goals that had data/information, two were met or progressing. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	413	450	412	189	429	410			

6	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/4 25% 2/8	0/2	-/-	0/1	-/-	1/3	1/2			
7	If personal goals were met, the IDT updated or made new personal goals.	N/A									
8	If the individual was not making progress, activity and/or revisions were made.	0% 0/4 0% 0/6	0/2	-/-	0/1	-/-	0/2	0/1			

Comments:
6-8. None of the individuals had achieved a goal in their ISPs.

Individual #429 and Individual #410 had made some progress towards their relationship goals.

For the remaining goals, the QIDP monthly review documented that action plans had not been implemented, thus, the individual had not made progress towards their goals.

For all individuals, few of the action plans in the ISP were consistently implemented.

QIDPs were reviewing action plans monthly, which was good to see, however, action was not routinely taken to revise action plans when progress was not made. Typically, IDTs were waiting until the next annual ISP meeting to revise plans.

Outcome 4: ISPs, assessments, and IDT participation support the development of a comprehensive and individualized annual ISP.

Summary: In general, ISPs were not implemented timely, relevant IDT members did not attend the annual meeting, and assessment were not obtained or updated. One aspect of this outcome showed sustained high performance, indicator 11a, regarding identifying needed assessments, and will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 413	450	412	189	429	410			
9	a. The ISP was revised at least annually (or was developed within 30 days of admission if the individual was admitted in the past year).	Due to the Center's sustained performance, this sub-indicator was moved to the category of requiring less oversight.									
	b. The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

10	The individual and all relevant IDT members participated in the planning process and attended the annual meeting.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			
11	a. 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			
	b. The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
	c. Assessments were updated as needed in response to significant changes.	0% 0/2			0/1	0/1					

Comments:

9b. The ISP was not implemented within 30 days of the meeting for any of the individuals. For all individuals, multiple action plans had not been implemented.

10. Two of the six individuals (Individual #429, Individual #410) had appropriately constituted IDTs, based on their strengths, needs and preferences, who participated in the planning process. Findings included:

- Individual #412, Individual #189, and Individual #450 did not attend their annual ISP meeting. Documents included evidence of the IDTs offering supports and encouraging them to attend, however, there was no evidence that they participated in the planning process (i.e., provided input on goals).
- Individual #413's dietician did not attend the annual ISP meeting. The individual was at high risk for weight gain. Despite being on a weight reduction diet, Individual #413 had gained 36 pounds the previous year. The dietician's input would have been beneficial when developing strategies to reduce this risk.

Annual ISP meetings were observed for Individual #412 and Individual #413. It was good to see that both individuals were encouraged to participate in their meetings and had input into goals for the upcoming year. It was particularly nice to see that Individual #413's IDT rearranged the meeting agenda order to encourage her participation in areas that were important to her.

11a. For all individuals, the IDT considered what assessments the individual needed and would be relevant to the developments of the ISP prior to the annual meeting.

11b. One of the IDTs (Individual #189) arranged for and obtained the needed, relevant assessments prior to the IDT meeting. For five individuals, IDTs were waiting on assessments to determine preferences and/or needs prior to moving forward with developing action plans related to achievement of goals. Some assessments were either not completed at the time of review or were completed months after ISP development, thus, identification of training needed was delayed and individuals were not making progress towards goals. Examples included:

- For Individual #412, her audiological assessment was not submitted prior to her annual ISP meeting. Assessments needed that were identified at her ISP Preparation meeting but not completed prior to her ISP meeting included assessing her social skills, skills needed for operating a microwave using an air fryer, budgeting, and skills needed for working at the greenhouse.

- For Individual #413, assessments needed that were identified at her ISP Preparation meeting but not completed prior to her ISP meeting included assessing her skills related to using an air fryer, cooking on the stove top, cooking in the oven, kitchen safety, and pool therapy.
- For Individual #450, the IDT was waiting on assessments related to the following skills: multiplication, spelling and writing, money management, and animal safety prior to developing individualized training.
- For Individual #429, the following assessments were not timely for her ISP meeting: audiological, annual medical, and psychiatric evaluation. The IDT had also identified the need to assess her knowledge of community signs and symbols prior to developing training.
- For Individual #410, his audiological, dental, and annual medical assessments were not submitted on time. His ISP also indicated that the IDT was waiting on assessments for using an analog clock, identifying community signs, following a schedule, social skills/boundaries, and industrial cleaning.

11c. For two individuals assessments were not updated as needed in response to significant changes.

- Individual #412's IDT met numerous times to address an increase in medication refusals and peer-to-peer aggression. The IDT repeatedly recommended that she be assessed for a medication related skill acquisition program and social skills training. There was no documentation to show that the assessments were completed.
- Individual #189 experienced a decline in health over the previous year. IDT members reported that he had a loss in his functional skills, including communication. His ISP indicated that further assessments would be completed to determine his interests and needs within 45 days of his annual ISP meeting. There was no evidence that assessments had been completed to determine what current supports were needed or what areas the IDT should focus on to support him to maintain his skill level. He had been diagnosed with anemia over the past year. There was no evidence that assessments had been completed to determine possible causes of his anemia.

Outcome 5: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: Some indicators were met for some individuals. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 413	450	412	189	429	410			
12	There was a thorough examination of living options.	67% 4/6	0/1	1/1	1/1	0/1	1/1	1/1			
13	a. ISP action plans integrated encouragement of community participation and integration.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			
	b. 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	1/1	0/1	0/1	0/1	1/1			
14	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			

15	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			

Comments:

12. For four individuals, there was a thorough examination of living options.
    - Individual #189's assessments noted that they had a hard time telling if he was happy at San Angelo SSLC. He stated that he wanted to live with his former guardians. The ISP goal was to remain at San Angelo SSLC. It was not evident that the IDT had considered other possible living options.
    - Individual #413's ISP noted that she often changed her mind about where she wanted to live. She told the IDT that she would like to return to Lubbock SSLC. It was noted that she had not visited any group homes in the community. Her goal was to live in an apartment in Lufkin.

13a. Five ISPs integrated encouragement of community participation and integration. The exception was Individual #189's ISP. He had a goal to go on two community outings, however, action plans did not support meaningful community integration.

13b. Individual #450 and Individual #410's ISPs considered opportunities for day programming in the most integrated setting consistent with preferences and support needs. Day and work opportunities were limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting.

- Individual #450 had a goal to volunteer at the animal shelter. Her goal was likely to lead towards developing skills that would support her to work in the community when she graduated from school.
- Individual #410 had a goal to work in his family's taco truck, however, action plans did not support him working in a less restrictive setting.
- Individual #412 stated that she did not like jobs that she had been offered at the center because they were boring, and she did not make enough money. She wanted to work in the community. The IDT did not discuss community employment or assess her for jobs that she might be interested in at the center.
- Individual #429 was 30 years old. She did not have a work/day goal. She told her IDT that she wanted to work at a restaurant in the community. She stated that she did not like work offered to her at the center. The IDT did not complete a vocational assessment that identified her vocational preferences and training needed for future employment. During observations, she was not engaged in meaningful activity during the day. When interviewed, she stated that she wanted to work in town and nobody was helping her with that.
- Individual #189 was attending day programming at his home. The ISP noted that he had enjoyed working in the past and would consider employment when his health improved. He had no related action plans to learn new skills or return to work. He was not functionally engaged during observations.
- Individual #413's IDT had not identified her work preferences or training needs related to employment. She refused to attend the workshop because she did not like the work offered to her. It was positive to see that at her annual ISP meeting observed, the IDT agreed to offer her opportunities for more challenging jobs at the center that matched her stated preferences.

14. None of the ISP action plans included individualized measurable plans to educate the individual/ LAR about community living options.

15. Individual #429 had been referred to the community. Her ISP included some broadly stated action plans related to transition, however, they did not include enough detail to offer the IDT guidance on transition. For the other five individuals, IDTs had not created individualized, measurable action plans to address identified obstacles to referral.

Outcome 6: Individuals' ISPs are implemented, progress is reviewed, and supports and services are revised as needed.

Summary: It was good to see that staff were knowledgeable about the individuals they supported. Few action plans were implemented. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 413	450	412	189	429	410			
16	Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
17	Action plans in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

16. For all individuals, staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans.

17. For all individuals, action plans had not been implemented and individuals had not made progress towards their goals. There was a total of 87 action steps evaluated, 18 (21%) of which had been consistently implemented.

Individual	# of Action Steps in ISP	Action Steps Implemented	Action Steps Not Fully Implemented
Individual #412	15	0	12
Individual #410	14	4	10
Individual #450	10	1	19
Individual #413	14	4	10 (did not include 3 on hold for Covid)
Individual #429	25	5	20
Individual #189	9	4	5

18. QIDPs did not ensure the individual received required monitoring/review and revision of treatments, services, and supports. QIDPs were consistently reviewing goals and action plans and commenting on progress, however, plans were not revised, and barriers

had not been addressed when services and supports were either not implemented or not effective. When support needs changed, IDTs did not always meet, as required, to revise supports. Examples included:

- Individual #410's IDT did not meet to develop new action plans to support his transition to a new facility.
- When Individual #189 was removed from hospice, the IDT did not meet to revise his supports to ensure that he had adequate opportunities for engagement and skill building.

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 and update the IRRFs within no more than five days. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
a.	The individual's risk rating is accurate.	8% 1/12	0/2	0/2	0/2	0/2	0/2	N/R	N/R	1/2	N/R
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% 4/12	1/2	0/2	1/2	1/2	1/2			0/2	

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IRRFs addressing specific risk areas [i.e., Individual #189 – aspiration, and circulatory; Individual #412 – fractures, and constipation/bowel obstruction; Individual #137 – respiratory compromise, and diabetes; Individual #203 – skin integrity, and gastrointestinal (GI) problems; Individual #410 – seizures, and cardiac disease; and Individual #319 – falls, and infections].

a. The IDT that effectively used supporting clinical data, and used the risk guidelines when determining a risk level was for Individual #319 – falls.

b. For the individuals in the review group, it was positive that the IDTs updated the IRRFs at least annually.

However, often when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #189 – aspiration, Individual #203 – GI problems, and Individual #410 – seizures.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: At San Angelo SSLC, there was progress in the sub-indicators of each of the indicators in this outcome. The psychiatry department was identifying indicators for reduction and in some cases for increase. The psychiatry clinicians need to ensure that the relationship of the indicator to the individual's diagnosis is clearly designated and that indicators are consistently identified. The psychiatric clinicians were regularly defining the indicators and writing goals associated with at least one indicator. These goals were not entered into the facility's overall treatment program, the IHCP. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
5	The individual has goals related to psychiatric status.	N/A									
6	Psychiatry goals are documented correctly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

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.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SC 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 progress in this area as all individuals in the review group had a psychiatric indicator related to the reduction of psychiatric symptoms. At least one of the indicators for reduction was also identified as a behavioral health target behavior for Individual #413, Individual #376, Individual #300, Individual #412, Individual #471, and Individual #189. The consistent identification of indicators across psychiatric documentation and activity was noted as an issue in all cases. For example, regarding Individual #412, the indicators noted in the goals grid were aggression, property destruction, stealing, and disruptive behavior. In another section of the document, indicators were noted as aggression, property destruction, disruptive behavior, and stripping. Physical aggression, property destruction and disruptive behavior were also behavioral health target behaviors. In another example, regarding Individual #383, there were three indicators for reduction noted in the psychiatry goals grid, improve ADLs, not interacting with others, and responding to unseen stimuli. While these were similar to the behavioral health indicators noted in the PSP, they were not identical. Per the PSP, the indicators were to reduce unusual thought content, emotional withdrawal, and self-neglect. Although the two sets of indicators were similar, they were not consistent. In another example regarding Individual #413, the indicator for reduction documented in the psychiatry goals grid was aggression, which was the same as a behavioral health target behavior. The indicators were inconsistently identified in the psychiatric documents. The grid only included aggression. Other indicators noted in other sections of the psychiatric documentation included threatening others, voicing homicidal thoughts or actions to harm or kill others, and voicing suicidal thoughts or actions to harm or kill self. Given these examples, it was apparent that psychiatry needs to review the indicators to ensure that they are consistently identified and consistent with those utilized by behavioral health to monitor psychiatric symptoms.

Generally, when a psychiatric indicator was identified and included in the psychiatry goals grid, there was a statement relating the indicator to a specific diagnosis. Psychiatric clinicians need to review these as in some cases, the related diagnosis was not consistent with the diagnosis documented in other sections of the document. For example, regarding Individual #450, per the psychiatry goals grid, the identified indicator was a "function of her bipolar disorder, conduct disorder, and PTSD." But, the diagnoses in other documents was Schizophrenia and Anxiety Disorder.

When an indicator is identified and related to a specific diagnosis, the next step is to define the indicator such that staff recording the presence of a specific indicator will be able to correctly identify the indicator. When indicators were the same as a behavioral health target behavior, behavioral health generally defined the indicator. When indicators were different, psychiatry needed to specifically define the indicator. Indicators for reduction required definition for Individual #376, Individual #383, and Individual #201. For Individual #383, this was an issue as noted above as the indicators identified by psychiatry were similar, but different than those utilized by behavioral health for the PSP.

Six of the individuals in the review group had psychiatric indicators for increase in positive/desirable actions identified. In three examples, regarding Individual #413, Individual #300, and Individual #412, the indicator for increase was medication compliance, measured by the number of medication refusals documented for a specific individual. In the other three cases, regarding Individual #383, Individual #201, and Individual #189, the indicator for increase was attendance or participating in a specific activity. Participation indicators must be clearly defined as attendance and participation is difficult to assess. For example, does the individual have to just present to a specific activity, do they have to participate for a period of time, or do they have to complete a specific task.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for five individuals in the review group and for three 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.

The psychiatric goals regarding the indicators for increase and decrease met monitoring criteria in that they included a measurement, the modality or scale that would be used to obtain the measurement, and a time metric. The psychiatry goals grid typically noted that direct care staff or behavioral health staff would collect data and enter it into Care Tracker.

As 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.

Thus, both sub-indicators were met for nine of the individuals for goals for reduction and for three individuals for goals for increase. Individual #376, Individual #450, and Individual #471 did not have indicators for increase identified. And although Individual #383, Individual #300, and Individual #412 and an identified indicator for increase, goals were not developed.

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, goals for reduction and increase were written for the identified indicators and documented in the psychiatry goals grid as noted above. But, the goals were not incorporated into the Center's overall documentation system, 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.

At San Angelo SSLC, data regarding indicators for decrease, when included in the psychiatric documentation, were presented as a series of numbers with no additional documentation regarding the reliability or validity of the data. Information regarding reliability and validity were requested for review, but were not submitted. Data regarding indicators for increase were located for Individual #413. These data were a report of medication refusals. As these data were based on the medication administration record, they were considered reliable.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Most of the documentation requirements of these indicators were not met. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 413	376	383	300	450	201	412	471	189
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
15	If admitted 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.	33% 1/3					1/1		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.	11% 1/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

14. The Monitoring Team looks for 14 components in the CPE. One of the CPEs included all of the required components. The other CPE, regarding Individual #471, was missing the medical history, laboratory examinations, and an adequate bio-psych-social formulation.

15. There were three individuals admitted in the two years prior to the review, Individual #450, Individual #471, and Individual #412.
    - Individual #450 had a CPE completed within the required 30-day timeframe as well as an IPN from nursing and primary care within the first business day after admission.
    - Individual #412 did not have an initial CPE or an IPN from nursing and primary care within the first business day after admission.
    - Individual #471 had a CPE completed within the required 30-day timeframe and an IPN from nursing within the first business day. There was no IPN from primary care within the first business day after admission.

16. All records revealed inconsistent diagnoses with the exception of Individual #383.
    - For Individual #413, the AMA and the BHA, that did not include diagnoses including antisocial personality disorder and tobacco use disorder, were out of date as of early august 2021. Updated documents were requested, but not submitted.
    - For Individual #376, the BHA and the AMA included a diagnosis of OCD. The psychiatric documents did not specifically review this diagnosis. It was listed in the information prepopulated by IRIS. In a discussion with psychiatry, they indicated that OCD was a diagnostic consideration, but again, it was not specifically reviewed in the psychiatric documents.
    - For Individual #300, both the AMA and the BHA were out of date. Updated evaluations were requested in the supplemental document request, but not submitted for review. There was a diagnosis of somatization disorder noted in the out of date AMA, and this was also noted by psychiatry in 2020. This diagnosis was not currently indicated by psychiatry.
    - For Individual #450, it was difficult to determine her current diagnoses. On admission, she had nine different diagnosis with six of them designated as a rule out diagnosis. The AMA included a diagnosis of Oppositional Defiant Disorder, the BHA had diagnoses of Bipolar Mood Disorder, Conduct Disorder, and Posttraumatic Stress Disorder. In psychiatry, the current diagnoses included Schizophrenia and Anxiety Disorder. There is a need for the team to determine this individual's diagnoses.
    - For Individual #201, the BHA did not include the diagnosis of Schizophrenia.
    - For Individual #412, both the BHA and AMA expired 9/9/21. Updated documents were requested, but not submitted. The BHA submitted included a diagnosis of personality disorder, unspecified that was not included in the psychiatric documents.
    - For Individual #471, psychiatry included a diagnosis of Posttraumatic Stress Disorder, but the psychiatric documentation was inconsistent as there was also a diagnosis of Schizoaffective Disorder noted on some documents. The BHA included a diagnosis of Schizoaffective Disorder and Intermittent Explosive Disorder. The AMA included diagnoses of Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder.
    - For Individual #189, the AMA was out of date as of 1/28/21. An updated AMA was requested via a supplemental document request, but not received.

When reviewing the above information, it is apparent that the IDT needs to determine the individual's diagnosis and document it consistently to allow for cohesive treatment across disciplines.

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

Summary: It was good to see psychiatrist attendance at ISP meetings (indicator 29). Psychiatry ISP-related documentation needed improvement. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 413	376	383	300	450	201	412	471	189
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. The Monitoring Team scores 16 aspects of the annual evaluation document. Eight individuals required annual evaluations. None of the annual evaluations completed contained all of the required elements. One evaluation was missing five elements, two evaluations were missing four elements, and four evaluations were missing two elements. The most common missing element was the symptoms of the diagnosis, missing in all seven evaluations. The evaluations included the diagnostic criteria for a particular diagnosis, but did not indicate what symptoms an individual experienced indicating that they met the criteria. Overall, these evaluations were difficult to follow. They included a great deal of cut and paste information from prior evaluations making the current evaluator's determinations difficult to discern.

- The annual evaluation regarding Individual #413 was missing the symptoms of the diagnosis, the psychological assessment or behavioral health assessment, the combined Behavioral Health review/formulation, and past pharmacology.
- The annual evaluation regarding Individual #383 was missing symptoms of the diagnosis, the psychological assessment or behavioral health assessment, the combined Behavioral Health review/formulation, and past pharmacology.
- The annual evaluation regarding Individual #300 was missing the symptoms of the diagnosis and the risk versus benefit discussion.
- The annual evaluation regarding Individual #201 was missing the psychiatric diagnosis and the symptoms of the diagnosis.
- The annual evaluation regarding Individual #412 was missing the symptoms of the diagnosis and past pharmacology.
- The annual evaluation regarding Individual #471 was missing the symptoms of the diagnosis, the psychological assessment or behavioral health assessment, the combined Behavioral Health review/formulation, the risk versus benefit discussion and past pharmacology.
- The annual evaluation regarding Individual #189 was missing the symptoms of the diagnosis and past pharmacology.

20. The psychiatrist attended the ISP meeting for eight 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:			Individuals:									
#	Indicator	Overall Score										
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.												
Summary: Criteria were met for all indicators for three individuals. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	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	1/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1
30	A risk versus benefit discussion is in the consent documentation.	56% 5/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	67% 6/9	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
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 seven of the individuals in the review group. Consent forms were not provided for Individual #376 and Individual #412. Individual#376 did not have current consents during the time of the monitoring review; it was corrected during the monitoring review week. Individual #412 had consents for some of her medications, but not all (Zoloft expired March 2021).

29. The consent forms included adequate medication side effect information in five examples. While the facility included some medication side effect information on the consent forms, they had also begun to include medication side effect information sheets with consent forms. This was good to see.

30. A sufficient risk versus benefit discussion was included in the consent forms in five examples. There were no consent forms submitted for Individual #376 and Individual #412. For Individual #189 and Individual #471, there was a need to address the

cumulative risk associated with the combination of medications. Individual #189 was prescribed a benzodiazepine in combination with an opiate and Individual #471 was prescribed two antipsychotic medications.

31. The consent forms for six individuals in the review group included alternate, non-pharmacological interventions in addition to the PBSP or PSP. Consent forms were not submitted for Individual #376 and Individual #412. For Individual #383, the consent forms indicated that the alternative to medication included a PBSP, but she has a PSP.

Psychology/behavioral health

At a previous review, the Monitor found that that the Center achieved and maintained substantial compliance with the requirements of section K of the Settlement Agreement and, as a result, was exited from section K of the Settlement Agreement.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.

Summary: If Medical Department staff continue their progress in ensuring the timely completion of annual medical assessments, then after the next review, Indicator b might move to the category requiring less oversight. For seven of the nine individuals in the review group, PCPs also completed timely interim medical reviews (IMRs). At this time, these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: b. It was positive that for the nine individuals in the review group, PCPs completed timely AMAs.

c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very

select individuals who are medically stable"). It appeared that PCPs at San Angelo SSLC were often following this guidance. The exceptions were for Individual #189, and Individual #137, both of whom were missing one of the three necessary reviews.

Outcome 3 – Individuals receive quality routine medical assessments and care.

Summary: Center staff should continue to improve the quality of the medical assessments, particularly with regard to, as applicable to the individual, family history, past medical histories, and thorough plans of care for each active medical problem, when appropriate. Indicators a and c will remain in active oversight.

Individuals:

#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
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.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2

Comments: a. Problems varied across the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, and pertinent laboratory information. Most, but not all included pre-natal histories, social/smoking histories, childhood illnesses, complete interval histories, complete physical exams with vital signs, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include as applicable, family history, past medical histories, and thorough 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 #189 – diabetes, and abdominal aortic aneurysm; Individual #412 – osteoarthritis, and hypertension; Individual #137 – chronic kidney disease (CKD), and osteoporosis; Individual #203 – seizures, and sarcoidosis; Individual #410 – osteoporosis, and partial complex and pseudo seizures; Individual #247 – tobacco dependence, and dystonia; Individual #429 – respiratory compromise/asthma, and weight; Individual #319 – tobacco use disorder, and constipation/bowel obstruction; and Individual #343 – nicotine dependence, and colon polyps].

The IMRs that followed the State Office template, and provided necessary updates related to the risks reviewed included those for: Individual #429 – weight, and Individual #343 – colon polyps.

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.

Individuals:

#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
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.	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 IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #189 – diabetes, and abdominal aortic aneurysm; Individual #412 – osteoarthritis, and hypertension; Individual #137 – CKD, and osteoporosis; Individual #203 – seizures, and sarcoidosis; Individual #410 – osteoporosis, and partial complex and pseudo seizures; Individual #247 – tobacco dependence, and dystonia; Individual #429 – respiratory compromise/asthma, and weight; Individual #319 – tobacco use disorder, and constipation/bowel obstruction; and Individual #343 – nicotine dependence, and colon polyps).

None of the IHCPs 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.

b. As noted above, per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). As a result, IHCPs no longer need to define the parameters for interval reviews, so the Monitoring Team did not rate this indicator.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.

Summary: Overall, the lack of a dentist at the Center or alternative arrangements for the provision of general dentistry services negatively impacted the provision of timely dental examinations, although some progress was noted with regard to the quality of dental examinations. Annual dental summaries were often not timely and were also often based on outdated dental examinations. As a result, IDTs did not have access to information about individuals' existing dental needs. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343

a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives a comprehensive dental examination.	44% 4/9	0/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1
c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: Individual #203 and Individual #343 were edentulous.

a. There was no dentist available at the Center to conduct examinations. In mid-July, the Center's Dental Director separated from the Center. In mid-May, a new Registered Dental Hygienist (RDH) was hired. There was one Dental Assistant who had been working at the Center since June 2020. During interview, Center staff reported that there was an arrangement with a community oral surgeon and endodontist. There was no arrangement to provide general dentistry services, nor was there any arrangement to provide general dentistry services in a hospital setting, if required. The Dental Clinic staff affirmed this information in response to a written document request submitted after the interview. The result was that many individuals did not receive timely annual dental examinations or annual dental summaries that were based on current information about their dental needs. The following describes concerns noted:

- At the time of the review, the following individual did not have annual dental examinations within the last 365 days: Individual #410 (i.e., examination dated 8/14/20), Individual #429. (i.e., examination dated 8/14/20), and Individual #319 (i.e., examination dated 8/11/20).
- Eight individuals did not have current dental examinations that were within the last 365 days as well as no more than 90 days prior to the annual ISP meeting. For example, Individual #189, Individual #203, and Individual #429 had dental examinations that were within 90 days of the annual ISP meeting, but they were not completed within 365 days of the previous examinations. Although annual dental examinations were completed within 365 days for the following individuals, the examinations were more than 90 days prior to the annual ISP meeting date: Individual #137, Individual #203, Individual #247, Individual #429, Individual #319, and Individual #343.
- As a result of the lack of timeliness with regard to annual dental examinations, most individuals did not receive an annual dental summary that had current dental information and was available to the IDT at least 10 working days prior to the annual ISP meeting. Instead, the annual dental summaries were often based on annual dental examinations that were not current (i.e., more than 90 days before the annual ISP meeting). Annual dental summaries affected were for Individual #189, Individual #137, Individual #410, Individual #203, Individual #247, Individual #429, Individual #319, and Individual #343.

b. As noted above, the Center did not submit a current dental examination for #410, Individual #429, and Individual #319. For Individual #412, Individual #203, Individual #247, and Individual #343, it was positive their comprehensive annual dental

examinations included all of the required components. For Individual #189, the annual dental examination did not include the recall frequency; information regarding x-ray(s) and type of x-ray, including the date; a treatment plan; and, periodontal charting, while for Individual #137, the examination did not include a treatment plan.

c. Six of nine annual dental summaries were based on outdated dental exams. While the lack of an updated dental examination as the basis for developing the annual dental summary results in a negative score, the Monitoring Team is providing feedback on the quality of the dental summaries that were submitted regardless of the date of the examination.

It was positive the dental summaries reviewed for Individual #429 and Individual #343 included all the required components. However, both were based on outdated examinations, so they scored negatively overall. It was also positive that all of the remaining dental summaries included the following:

- Effectiveness of pre-treatment sedation;
- Recommendation of need for desensitization or another plan;
- A description of treatment provided (treatment completed);
- Number of teeth present/missing; and,
- Recommendations of risk level for IRRF.

Most of the remaining dental summaries included the following components, as applicable:

- Dental care recommendations; and,
- Treatment plan, including recall frequency;

Center staff should continue to focus on the following components:

- Dental conditions that could cause systemic health issues or are caused by systemic health issues; and,
- Provision of written oral hygiene instructions.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: For four out of six individuals reviewed, nurses completed timely quarterly nursing record reviews and physical assessments. For the remaining two individuals, nurses relied on physical assessments that were completed between a month and six weeks before the record reviews. This resulted in the quarterly reviews including out-of-date, and potentially inaccurate information. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
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	N/A	N/A	N/A	N/A	N/A	N/A	N/R	N/R	N/A	N/R
	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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.										
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	67% 4/6	1/1	0/1	1/1	1/1	1/1			0/1		

Comments: a.iii. With regard to quarterly nursing record reviews and physical assessments, examples of problems included:

- On 9/17/20, the RNCM completed Individual #412's annual record review, and on 10/6/20, the IDT held her annual ISP meeting. On 4/29/21, a quarterly record review was completed, but the physical assessment had been completed on 3/21/21, which did not provide up-to-date information for the quarterly assessment. Similarly, the RNCM completed a quarterly record review on 7/22/21, but relied on a physical assessment that was over a month old (i.e., dated 6/19/21).
- For Individual #319, the nurse completed a physical assessment on 12/1/20, and relied on this assessment when completing the quarterly record review six weeks later on 1/15/21.

Outcome 4 – Individuals have quality nursing assessments to inform care planning.

Summary: It was positive that for more than half of the risk areas reviewed, nurses included status updates in annual record reviews, and for more than 80% of the risks reviewed, the quarterly record reviews included relevant clinical data. Work is needed, though, for RNCMs to analyze this information, and offer relevant recommendations. Improvement continued with the content and thoroughness of other portions of the record reviews, as well as the annual and quarterly physical assessments. For 40% of the exacerbations of individuals' chronic conditions that the Monitoring Team reviewed, nurses completed assessments in accordance with current nursing guidelines. All of these indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
a.	Individual receives a quality annual nursing record review.	17% 1/6	0/1	0/1	0/1	1/1	0/1	N/R	N/R	0/1	N/R
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;	0% 0/6	0/1	0/1	0/1	0/1	0/1			0/1	

	iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.										
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% 0/12	0/2	0/2	0/2	0/2	0/2			0/2	
d.	Individual receives a quality quarterly nursing record review.	17% 1/6	0/1	0/1	0/1	1/1	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; vi. Pain; and vii. Follow-up for abnormal physical findings.	0% 0/6	0/1	0/1	0/1	0/1	0/1			0/1	
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% 0/12	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.	40% 4/10	0/1	0/2	2/2	1/1	1/2			2/2	

Comments: a. It was positive that all of the annual nursing record reviews for individuals in the review group 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 the time of the ANA;
- Immunizations;
- Consultation summary;
- Tertiary care; and
- Allergies or severe side effects to medication.

The components on which Center staff should focus include:

- Family history;
- Social/smoking/drug/alcohol history; and

- Lab and diagnostic testing requiring review and/or intervention.

Of note, many of the annual nursing record reviews included most of the required components. With minimal effort, nurses could make continued progress on the quality of the annual nursing record reviews.

b. and e. Common problems with the annual and quarterly nursing physical assessments included a lack of follow-up for abnormal findings, and a lack of abdominal circumference measurements.

c. and f. For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #189 – aspiration, and circulatory; Individual #412 – fractures, and constipation/bowel obstruction; Individual #137 – respiratory compromise, and diabetes; Individual #203 – skin integrity, and GI problems; Individual #410 – seizures, and cardiac disease; and Individual #319 – falls, and infections).

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. However, on a positive note, nurses included status updates, including relevant clinical data, for over half of the risk areas reviewed in the annual assessments (i.e., Individual #189 – aspiration, and circulatory; Individual #412 – fractures; Individual #137 – respiratory compromise; Individual #410 – seizures; and Individual #319 – falls, and infections), and for about 80% of the risk areas reviewed in the quarterly assessments (i.e., Individual #189 – aspiration; Individual #412 – fractures, and constipation/bowel obstruction; Individual #137 – respiratory compromise, and diabetes; Individual #203 – skin integrity, and GI problems; Individual #410 – seizures; and Individual #319 – falls, and infections).

Unfortunately, nurses generally had not analyzed this information (i.e., the exception was for Individual #189 – aspiration), including comparisons with the previous quarter or year, and/or made necessary recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

In addition, it is essential in annual and quarterly assessments that nurses provide specific dates. At times, individuals' clinical stories were unclear, because dates of various events or summary data were missing.

d. It was positive that all of the quarterly nursing record reviews for individuals in the review group included the following, as applicable:

- Active problem and diagnoses list updated at the time of the quarterly assessment;
- Procedure history;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Immunizations;
- Tertiary care; and
- Allergies or severe side effects to medication.

Most, but not all of the quarterly nursing record reviews for individuals in the review group included, as applicable:

- Family history;

- Consultation summary; and
- Lab and diagnostic testing requiring review and/or intervention.

The component on which Center staff should focus include:

- Social/smoking/drug/alcohol history.

g. The following are examples of when assessing exacerbations in individuals' chronic conditions (i.e., changes of status), nurses adhered to nursing assessment guidelines in alignment with individuals' signs and symptoms:

- In an IPN, dated 5/3/21, at 2:12 p.m., a nurse indicated that staff reported that Individual #137 looked like she was having trouble breathing. Nursing assessment findings noted an episode of vomiting that morning. The individual had an acetone/sweet smell to her breath, and her blood sugar was 198. The nurse notified the PCP. The nurse documented that: "She was also noted to have crackles in the right base of the lungs and noted rest of the fields are clear. Order for breathing treatment." Based on her signs and symptoms, the nurse followed the nursing guideline for respiratory compromise and hyperglycemia, including assessing full vital signs.
- In an IPN, dated 5/6/21, at 4:50 p.m., a nurse indicated that staff brought Individual #137 to the nurse, because she was not acting like herself, was communicating much less than usual, staring, and she did not tell staff she needed to use the bathroom resulting in her soling herself. The nurse conducted and documented an assessment that showed low oxygen saturation, and lung sounds revealed bilateral crackles in the lower lobes. The nurse noted relevant symptoms, including that the individual had vomited in her bed several days ago. The nurse applied supplemental oxygen, and notified the PCP. The individual was transferred to the ED via 911. The PCP ordered nebulizer treatment while the individual was awake, which the nurse noted was administered. Based on the individual's signs and symptoms, the nurse followed the nursing guidelines for respiratory distress.
- According to an IPN, dated 2/2/21, at 6:36 a.m., Individual #203 had a small blister to the right big toe. The nurse conducted an assessment of the individual's vital signs, and a pain assessment. The nurse noted the blister appeared to be friction related. The nurse documented the size of the injury, including length, width, and depth. The nurse followed the nursing guidelines for assessing a skin impairment.
- In an IPN, dated 6/10/21, at 4:00 p.m., a nurse indicated that staff reported that Individual #410 experienced seizure-like activity. The objective findings indicated that the individual showed signs of seizure-like activity, including mild convulsions. He was sweating with his eyes fluttering from 4:00 p.m. to 4:05 p.m. Staff placed him in the side-lying position. The nurse documented that after the administration of Diastat, the individual responded to commands, and was able to report back what happened while he was having his seizure. The nurse notified the PCP. The nurse followed the nursing guidelines for seizures, as well as the individual's seizure management plan.

The following provide a few examples of concerns related to nursing assessments in accordance with nursing guidelines or current standards of practice in relation to exacerbations in individuals' chronic conditions (i.e., changes of status):

- In an IPN, dated 2/7/21, at 1:55 p.m., the PCP noted that a Licensed Vocational Nurse (LVN) called to report that Individual #189's blood pressure was 175/105. The PCP instructed the LVN to administer Clonidine and monitor the individual's blood pressure to ensure that it fell below 150 systolic and 100 diastolic. The PCP ordered initiation of Metoprolol-ER [extended release] 25 milligrams (mg) daily with the first dose the following day, when available. In IView entries, dated 2/7/21, at 1:55 p.m., a nurse documented that the individual's blood pressure was 174/105, and his heart rate was 90. In the submitted

documents, no nursing IPN was found to document the nurse's notification of the PCP. In addition, based on review of IPNs and IView entries, no evidence was found that nursing staff conducted assessments to determine whether or not the individual was having pain or other symptoms of heightened blood pressure, such as a headache, or dizziness. In a Medication Effectiveness Evaluation note, dated 2/7/21, at 8:30 p.m., a nurse stated that the Clonidine was effective.

- In a revised Post-Injury report, dated 5/7/21, at 4:45 p.m., a nurse stated that they received a call requesting a follow-up assessment of Individual #412's right ankle injury. The Post-Injury report indicated that the original injury took place on 4/29/21. IPNs stated that the individual was trying to walk in high heel shoes when she inverted her ankle. On 4/29/21, the PCP saw the individual in her home, and she was treated with rest, ice, compression, and elevation (RICE), and use of a wheelchair. The individual was able to bear weight, and follow-up was scheduled for 5/3/21. According to the note on 5/7/21, the individual did not attend the follow-up appointment. Based on the individual's signs and symptoms, the nurse completed an assessment of the swelling and circulatory status of her right ankle, and pain. The nurse noted the individual refused vital signs. Nevertheless, a respiratory rate, which does not require the individual's participation, was not documented. According to the PCP's Assessment and Plan, dated 5/7/21, the x-ray findings showed a nondisplaced fracture of the tip of the lateral malleolus of the right ankle.
- Based on documentation submitted, on 6/7/21, 6/13/21, and 6/30/21, Individual #412 required medication for constipation. No IPNs were found to show that nursing staff completed the necessary follow-up to determine the effectiveness of the pro re nata (PRN, or as needed) medication, nor did the IView entries indicate that the Medication Administration Record (MAR) included a comment.
- As two examples, on 6/26/21, Individual #410 had a blood pressure reading of 135/87, and on 6/29/21, it was 135/86. His stated parameters were 130/80. However, for these examples, nursing staff did not reassess his blood pressure.
- According to a Post-Injury Report, dated 6/8/21, at 11:34 a.m., and corresponding IView entries, staff reported that Individual #319 was walking fast near the Canteen, tripped, and fell. Nursing staff followed the nursing guidelines for a fall assessment. However, the Post-Injury report and IView entries also indicated that the individual had a superficial scrapes on her left knee and right knee, as well as right hand redness, and left hand redness. In the Post-Injury Report, a nurse documented cleaning all four areas with warm water and Hibiclens, rinsing them with water, then gently patting them dry with clean 4x4 gauze, applying triple antibiotic ointment, and leaving them open to air. The nurse did not assess and/or document the measurements of the superficial scrapes/scratches on the left and right knees, which is necessary to determine whether or not they are healing.
- According to an IPN, dated 4/16/21, at 2:27 a.m., a nurse documented that staff reported that Individual #319 complained of foot pain. The nursing assessments documented that the individual was agitated, refused vital signs, and referred to herself by a different name. The nurse visually inspected the individual's feet, and observed breakdown bilaterally to the nail bed, toes, and balls of her feet. In the IPN, the nurse indicated that they were unable to assess capillary refill as a result of severe discoloration to the nail beds, and that they were unable to determine the stage of breakdown. IView entries, dated 4/16/21, at 2:01 a.m., only noted no vital signs. An IPN stated that nursing staff were to follow up in morning to further assess and treat. In the next IPN, dated 4/16/21, at 1:52 p.m., a nurse indicated that the individual said: "…my feet hurt." The nurse documented an assessment that included removing the individual's shoes and socks. The nurse noted 2+ pitting edema, macerated heels, redness and warmth to the touch of the individual's toes, and "very filthy feet." The nurse subsequently referred the individual to the clinic, requesting an appointment due to blisters on both feet. The nurse did not describe the blisters in the IPN. No corresponding IView entries were found for vital signs or an indication that the individual refused. In a

corresponding medical IPN, dated 4/16/21, at 4:25 p.m., a provider documented an assessment of cellulitis and disrupted toenails. The provider ordered Levaquin, Ibuprofen, a podiatry appointment, nail cleaning with Hibiclens, triple antibiotic ointment, and warm betadine soaks for seven days. In the initial and subsequent IPNs, nursing staff did not include any measurements of the individual's skin integrity issues (i.e., "macerated heels"). Moreover, given that the individual complained of pain, the time between the initial nursing assessment and the next assessment was not consistent with generally accepted standards of care.

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 been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
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% 0/12	0/2	0/2	0/2	0/2	0/2	N/R	N/R	0/2	N/R
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/12	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% 0/12	0/2	0/2	0/2	0/2	0/2			0/2	
d.	The IHCP action steps support the goal/objective.	0% 0/12	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).	25% 3/12	0/2	1/2	0/2	0/2	0/2			2/2	
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	42% 5/12	0/2	2/2	1/2	0/2	0/2			2/2	

Comments: a. through f. The IHCPs reviewed all included nursing interventions, but were missing key nursing supports. For example, RN Case Managers and IDTs generally had not individualized interventions in relevant nursing guidelines and included in the action steps of IHCPs specific assessment criteria for regular nursing assessments at the frequency necessary to address conditions that placed individuals at risk [e.g., if an individual was at risk for skin breakdown/issues, then an action step(s) in the IHCP that defines the frequency for nursing staff to assess the color, temperature, moisture, and odor of the skin, as well as the drainage, location, borders, depth, and size of any skin integrity issues]. In addition, often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause(s) or etiology(ies) 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's adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.). Significant work is needed to include nursing interventions that meet individuals' needs into IHCPs.

b. IHCPs generally did not include preventative interventions. In other words, they did not include interventions for staff and individuals to proactively address the chronic/at-risk condition. Examples might include drinking a specific amount of fluid per day to prevent constipation, washing hands before and/or after completing certain tasks to prevent infection, etc.

e. The IHCPs that included specific clinical indicators for measurement were for: Individual #412 – fractures; and Individual #319 – falls, and infections.

f. The IHCPs that identified the frequency of monitoring/review of progress were for: Individual #412 – fractures, and constipation/bowel obstruction; Individual #137 – respiratory compromise; and Individual #319 – falls, and infections.

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. Similar to the last review, Center staff should focus on improving referral of all individuals that meet criteria for PNMT review, timely completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, as well as the quality of the PNMT comprehensive assessments.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	60% 3/5	N/A	0/1	1/1	0/1	N/A	1/1	N/A	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	40% 2/5		0/1	1/1	0/1		0/1		1/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	20% 1/5		0/1	0/1	0/1		0/1		1/1	

d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	50% 3/6		1/2	1/1	0/1		0/1		1/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 2/2		N/A	1/1	1/1		N/A		N/A	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/6		0/2	0/1	0/1		0/1		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 • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/1		0/1	N/A	N/A		N/A		N/A	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5		0/1	0/1	0/1		0/1		0/1	

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

- With regard to Individual #412:
  - On 4/29/21, she sustained an injury. On 5/6/21, an x-ray revealed a non-displaced fracture of the tip of the right lateral malleolus. Although this was not a fracture of a long bone, according to the PNMT assessment, on 5/21/21, there was a referral to the PNMT. The weekly summary stated that the referral was on 5/19/21. The PNMT chose to complete an assessment, which they initiated on 5/26/21. It was not completed until 8/11/21. Based on interview during the remote review, the delay was due to staffing issues and turnover. No evidence was found to show that a physician/PCP participated in the assessment process. The quality of the assessment is discussed below.
  - As early as March 2021, Individual #412 should have been referred to the PNMT, but no evidence was found of a referral or review. More specifically, on 11/5/20, she weighed 172.6 pounds. Four months later, on 3/2/21, she weighed 193.6 pounds (i.e., a 12% gain). She continued to gain weight, and weighed 200.4 pounds in April, 205.6 pounds in May, and 233.2 pounds on 8/4/21. Since November 2020, this represented a gain of 60.6 pounds. On 7/21/21, the PNMT held a change-in-weight discussion, following which they requested that staff reweigh her to confirm her weight. Based on documentation submitted, the IDT did not provide or the PNMT did not discuss results of reweighing her. The PNMT noted that staff denied any increase in her by-mouth (PO) intake. During the PNMT meeting, on 9/15/21 (i.e., during the week of the Monitoring Team's remote review), they identified that she had gained 57 pounds during the last year. They decided to do an evaluation for her at that time.

- On 5/3/21, during a bed check, staff discovered that Individual #137 had had a large emesis, and she was lying flat in bed, which was not consistent with head-of-bed elevation (HOBE) recommendations. A piece of gum was discovered in the emesis as well. On 5/6/21, staff reported that the individual had altered mental status, was staring with decreased communication, and she had soiled herself, which was unusual. When nursing staff assessed her, her oxygen (O2) saturation was 90 to 93%, and she had abnormal lung sounds. She was sent to the ED and admitted. On 5/11/21, the PNMT RN completed a post-hospitalization review. Due to the diagnosis of aspiration pneumonia, on 5/12/21, she was referred to the PNMT. On the same date, the PNMT initiated an assessment, but they did not complete it until 8/19/21. No evidence was found to show that a physician/PCP participated in the assessment process. The quality of the assessment is discussed below.

- From 10/2/20 to 10/6/20, Individual #203 was hospitalized for aspiration pneumonia. The PNMT did not appear to review the RN post-hospitalization review. More specifically, on 10/7/20, the RN conducted observations of the individual's enteral feeding. The RN recommended: 1) PT involvement, because the individual's wheelchair was reclined too far; and 2) an OT assessment for a sensory item to decrease the individual's finger-sucking. On 10/8/20, the PNMT RN made four recommendations, including the two previously made, as well as: 3) an evaluation to rule out gum pain or other mouth issues; and 4) a bed positioning assessment. On 10/8/20, a PNMT note reflected a post-hospitalization review, but only the nurse signed the note. There was no evidence that any other PNMT member participated. She mentioned "more than 2 triggers of aspiration or GERD for consecutive months" should result in referral to PNMT." She also recommended that the Home Manager retrain staff related to HOBE positioning to prevent aspiration and GERD within two weeks. No further follow-up or review was recommended other than a review by the Pneumonia Committee. There was no evidence of further follow up by the PNMT and no rationale for not assessing or reviewing her as a team.

- On 6/19/21, Individual #247 had his second choking event within a year (i.e., the first one occurred on 4/19/21). The Monitoring Team submitted its Tier II document request on 8/13/21. Based on documents submitted and confirmed through interview during the remote review, the PNMT had not completed a review and/or assessment. The PNMT weekly summary indicated that a Modified Barium Swallow Study (MBSS) was ordered, and then, reordered on 7/14/21. No evidence was found of follow-up. No PNMT IPNs were submitted.

- For Individual #319, on 9/24/20, the PNMT conducted a review and individualized criteria for re-referral to more than three falls in 30 days. On 5/31/21, she met criteria for referral to the PNMT due to having more than three falls in 30 days (i.e., she fell five times in May). On 6/1/21, she was referred to the PNMT. On 6/7/21, the PNMT initiated an assessment, which they completed on 7/14/21. No evidence was found to show PCP/provider involvement in the assessment, specifically related to potential medication side effects.

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, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #203, and Individual #247). The following summarizes some of the findings related to the three assessments that the PNMT completed:

- For Individual #412:

- As noted above, the PNMT completed the assessment three months after the fracture occurred, which limited its usefulness.
- It was positive that the assessment addressed:
  - The individual's behaviors related to the provision of PNM supports and services;
  - Evidence of observation of the individual's supports at his/her program areas;
  - Medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services; and
  - The potential causes of the individual's physical and nutritional management problems.
- Some of the concerns noted included:
  - The circumstances around the fracture differed in the assessment from the description in the PNMT monthly meeting notes. The PNMT did not reconcile these differences, making it unclear which was correct. The PNMT provided no rationale for waiting to complete assessment until after the fracture was resolved.
  - Although the section on transfers/mobility/balance section referenced her nine falls over the past year, the section on the risk analysis for fractures of the assessment included no discussion of her fall history.
  - In terms of providing evidence of observation of the individual's supports in program areas as well as the assessment of her current physical status, the PNMT reported information from previous OT/PT assessments in May after the initial injury. It was not clear that this was a PNMT assessment at the time of the injury and/or assessment. The PNMT provided no evidence of her current functional skills, other than that she had returned to her previous level of functioning, which was not described.
  - The PNMT stated that the IDT should discuss the related behavioral issues (i.e., related to the risk of falls, as well as delays in healing due to noncompliance) to ensure a plan was in place to address refusals. The PNMT cited that on 8/8/21, the IDT held a "root cause analysis" (RCA) meeting, but provided but no discussion of outcomes related to this meeting. The PNMT offered no additional recommendations.

- For Individual #137:
  - It was positive that the assessment included:
    - A description of the presenting problem;
    - Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
    - Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
    - The individual's behaviors related to the provision of PNM supports and services; and
    - Recommendations, including rationale, for physical and nutritional interventions.
  - Some of the concerns noted included:
    - The PNMT assessment listed the individual's prescribed medications with side effects, but provided no discussion of the relevance to supports or specifics in relation to the individual. For example, it was not clear whether she presented with any of the possible side effects listed.
    - The assessment took place in May and June, and that was when it appeared PNMT members completed observations. The PNMT provided no discussion of her current status (other than her status in May 2021), nor did they provide a rationale of why the assessment was not completed until August.

- The PNMT provided no clear description of her current motor performance related to her physical status and the aspiration pneumonia diagnosis. They covered positioning during her meal, nutrition, weight, dysphagia, oral hygiene, and HOBE in May/June, but not over the full course of the assessment, which was not completed until August, three months after aspiration pneumonia event.
- In terms of the effectiveness of current supports, the only issue the PNMT assessment addressed was HOBE. The PNMT determined that she would do better at 20 degrees, rather than at 15 degrees as previously prescribed. They did not present any comparative data from a HOBE evaluation to support this determination, only that staff reported that she appeared to be uncomfortable at 25 degrees.
- Prior to her most recent diagnosis of aspiration pneumonia, she was positioned flat in bed, and had a vomiting episode. She had a diagnosis of severe gastroparesis. The PNMT suggested that they did not know the cause of the delayed gastric emptying, however, and recommended that the cause of this should be determined via further imaging. It was not clear that the PNMT made this recommendation early in the assessment process so that they could analyze the findings prior to the completion of the assessment.
- With regard to the measurability of the recommended goals/objectives, the assessment identified the following goal: "will be positioned correctly when in bed with use of head of bed elevation to prevent vomiting due to reflux in 100% of PNMT observations in the next 3 months." The PNMT did not define "correctly," and nor did they provide a specific HOBE.

- The PNMT assessment for Individual #319et most of the criteria for quality. The concerns were related to recommendations for measurable goals/objectives, as well as indicators and thresholds. Specifically, the PNMT recommended no measurable IHCP goals related to the incentive plan details, her compliance with wearing her orthotics, or attending PT in town.

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

Summary: Some improvement was noted with regard to the inclusion of some of the necessary PNM interventions in IHCPs. For example, a number of the IHCPs reviewed included some preventive interventions, and/or they identified the frequency of monitoring/review of progress. However, overall, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause(s) or etiology(ies) of the PNM issues in the action steps. In addition, many action steps were not measurable.

The seven PNMPs/Dining Plans reviewed met the requirements for quality. Given that during the previous review, the Center's score was 63%, and problems noted during that review were minimal, if the Center sustains its progress overall, then, after the next review, Indicator c might move to the category requiring less oversight.

Individuals:

#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343

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).	24% 4/17	1/2	0/2	1/2	0/2	1/2	0/2	1/2	0/1	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	41% 7/17	2/2	0/2	1/2	0/2	1/2	0/2	1/2	0/1	2/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	24% 4/17	1/2	0/2	1/2	0/2	1/2	0/2	1/2	0/1	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	18% 3/17	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1	2/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	6% 1/17	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/1	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	71% 12/17	2/2	1/2	1/2	2/2	2/2	0/2	2/2	0/1	2/2

Comments: The Monitoring Team reviewed 17 PNM issues and, as available, the IHCPs that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #189 – falls, and choking; Individual #412 – fractures, and weight; Individual #137 – falls, and aspiration; Individual #203 – skin integrity, and aspiration; Individual #410 – falls, and choking; Individual #247 – falls, and choking; Individual #429 – skin integrity, and falls; Individual #319 – falls; and Individual #343 – choking, and falls.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exceptions were for: Individual #189 – falls, Individual #137 – falls, Individual #410 – choking, and Individual #429 – falls.

b. The ISPs/IHCPs reviewed that included preventative physical and nutritional management interventions to minimize the individuals' risks were for Individual #189 – falls, and choking; Individual #137 – falls; Individual #410 – choking; Individual #429 – falls; and Individual #343 – choking, and falls.

c. Seven of nine individuals in the review group had PNMPs and/or Dining Plans. It was positive that all seven of the PNMPs/Dining Plans included the necessary components and met the individuals' needs.

Given that during the previous review, the Center's score was 63%, and problems noted during that review were minimal, if the Center sustains its progress overall, then, after the next review, Indicator c might move to the category requiring less oversight.

d. The IHCPs that included the steps necessary to meet the measurable goal/objective were for: Individual #189 – falls, Individual #137 – falls, Individual #410 – choking, and Individual #429 – falls.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #189 – choking; and Individual #343 – choking, and falls.

f. The IHCP that identified triggers and actions to take should they occur was for: Individual #410 – choking.

g. Most of the IHCPs reviewed included the frequency of PNMP monitoring/review of progress, including those for: Individual #189 – falls, and choking; Individual #412 – weight; Individual #137 – falls; Individual #203 – skin integrity, and aspiration; Individual #410 – falls, and choking; Individual #429 – skin integrity, and falls; and Individual #343 – choking, and falls. Center staff showed continued improvement with this indicator.

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	189	412	137	203	410	247	429	319	343
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	0/1	N/A	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.	N/A				N/A					
Comments: a. and b. For Individual #203, in the IRRF, the IDT did not provide 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.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.	
Summary: The Center made progress in providing OT/PT assessments that were both timely and of the correct type in accordance with individuals' needs. 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	189	412	137	203	410	247	429	319	343
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.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	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; ▪ 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.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	13% 1/8	1/1	N/A	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. through c. For most individuals reviewed, OTs/PTs completed OT/PT assessments in a timely manner and conducted the correct type of assessment (i.e., screening, comprehensive, or update) in accordance with individuals' needs.
The exception was for Individual #412. Based on documentation provided, Center staff provided no evidence the PT completed needed assessments after she sustained a right ankle fracture on 4/29/21. For example, the PT did not complete an analysis of falls related to this fracture and it remained unclear how the fracture occurred. For example, the Physical Nutritional Management Team (PNMT) weekly summary, dated 5/19/21, indicated it occurred as a result of bumping into a food cart, but a PNMT assessment, dated 8/18/21, stated it resulted from the individual trying to walk in high heel shoes. There were reports of subsequent falls on 5/23/21, 6/1/21, 6/7/21, and 6/13/21, and PNMT documentation indicated nine falls occurred over the last year, but there was no further follow-up documented related to falls analysis or prevention.

d. It was positive that the comprehensive assessment reviewed for Individual #189 met all criteria for a quality assessment. It was also positive that all of the seven remaining assessments reviewed met criteria, as applicable, with regard to the following components:

- A 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); and,
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

Most, but not all met criteria, as applicable, with regard to:

- 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 pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services; and,
- Providing a functional description of fine, gross, sensory, and oral motor skills, and activities of daily living.

Center staff should continue to focus attention on the remaining sub-indicators:

- 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.

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: The Center made progress with regard to including a description in ISPs of how individuals function from an OT/PT perspective. Improvement is needed with regard to the remaining 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.			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	33% 3/9	0/1	1/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	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.	N/A									

Comments: a. Most of the ISPs reviewed included concise, but thorough descriptions of individuals' OT/PT functional statuses. The exception was for Individual #247, for whom the ISP documented a discussion of his falls and risk areas, and diagnoses, but did not provide an adequate description of how he functioned relative to his motor performance.

b. 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. OT/PT assessments often did not provide recommendations for needed OT/PT interventions for IDTs to consider and incorporate in ISP action plans. QIDPs and OTs/PTs should work together to make sure assessments provide recommendations for goals/objectives to address OT/PT needs, and that IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: It was positive that, as applicable, Center staff provided timely assessments that were also of the type in accordance with individuals' needs. Due to the Center's sustained performance, Indicators a.iii (Round 15 – 83%, Round 16 - 80%, Round 17 - 100%), and b (Round 15 – 86%, Round 16 - 89%, and Round 17 – 100%) will move to the category requiring less oversight. The Center still needed to focus on improving the quality of communication assessments 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.			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A			N/R		N/R	N/R			
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	100% 2/2	1/1	N/A		1/1			N/A	N/A	N/A
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 6/6	1/1	1/1		1/1			1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following:	N/A									

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

Comments: Individual #137, Individual #410, and Individual #247 were part of the outcome group, and did not have any specific communication-related supports, so these indicators were not rated for them.

a. through c. For the individuals reviewed, SLPs completed communication assessments in a timely manner and conducted the correct type of assessment (i.e., screening, comprehensive, or update) in accordance with individuals' needs.

d. It was positive that both comprehensive assessments reviewed met criteria, as applicable, with regard to providing a functional description of individuals' expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills. It was also positive that the comprehensive assessment for Individual #189 met criteria for most of the sub-indicators. The exception was integrating his preferences and strengths for use in the development of communication supports and services.

However, the comprehensive assessment for Individual #203 met criteria for only two of the applicable sub-indicators:

- The individual's preferences and strengths are used in the development of communication supports and services; and,
- 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.

The Center should focus on the following sub-indicators:

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

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

Summary: It was positive that for individuals in the review group, ISPs included a description of how the individuals communicated and how staff should communicate with the individuals. To move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals' communication dictionaries, strategies, and interventions in ISPs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
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.	100% 6/6	1/1	1/1	N/R	1/1	N/R	N/R	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	33% 1/3	1/1	N/A		0/1			N/A	N/A	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% 0/1	N/A	N/A		0/1			N/A	N/A	N/A
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: Individual #137, Individual #410, and Individual #247 were part of the outcome group, and did not have any specific communication-related supports, so these indicators were not rated for them.

a. The ISPs reviewed provided complete functional descriptions of individuals' communication skills.

b. The following describes concerns noted:

- For Individual #343, the ISP identified that he has difficulty processing what he wants to say and becomes easily sidetracked from the topic of discussion, likely as a result of his neurological decline secondary to head trauma. The ISP also provided specific instructions for others to use when communicating with him. For example, the ISP documented that a speaker should look for signs that he is comprehending (e.g., good eye contact, relaxed demeanor) and for signs that he is not comprehending what is being said (e.g., looking down, taking his hat off, stuttering or his arms moving about in frustration). However, despite all of these meaningful instructions related to non-verbal communication, he did not have a Communication Dictionary, nor did the PNMP include them for staff reference, and the IDT did not discuss his need for a Communication Dictionary.
- For Individual #203, the Center did not provide evidence that the IDT ensured the that her Communication Dictionary comprehensively addressed her non-verbal communication. The ISP indicated the IDT approved the Communication Dictionary and stated no changes were indicated. However, the SLP assessment stated that the action of lowering her head when offered something she did not want needed to be added. There was no evidence of discussion of this change. Moving forward, ISPs should provide evidence with regard to what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.

c. The SLP assessment for Individual #203 recommended additional use of "Put Em Arounds" to further reinforce using voice output devices (VODs) to potentially expand her expressive language skills. The assessment further suggested specific preferred activities that might be incorporated, such as catnaps, getting her hair brushed and listening to music. The IDT did not address this strategy in the ISP.

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: Most individuals had one SAP. More than half of the SAPs were not written in measurable terminology. This indicator (2) will remain in the category of requiring less oversight, but corrections need to occur to bring performance back to the high level seen in previous reviews. The choice of what skills to address with SAPs also needed improvement as noted in the comments below for indicator 4. Indicator 4 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
1	The individual has skill acquisition plans.										

2	The SAPs are measurable.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
3	The individual's SAPs were based on assessment results.										
4	SAPs are practical, functional, and meaningful.	43% 6/14	0/1	0/1	1/1	0/2	1/2	3/3	0/1	1/2	0/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
The Monitoring Team chooses three current SAPs for each individual for review. There were two SAPs to review for Individual #471, Individual #450, and Individual #300 and one SAP available to review for Individual #413, Individual #376, Individual #383, Individual #412, and Individual #189, for a total of 14 SAPs for this review.

2. The objectives for eight SAPs included multiple verbal or gestural prompts. For example, Individual #189's counting SAP objective was that he will count his decorations with two verbal prompts. The SAP data collection system, however, did not measure the frequency of prompts and, therefore, these objectives were judged to be unmeasurable. One strategy that could be utilized to address this issue in the future would be to specify in the SAP training sheet that no more than two prompts would be used following an incorrect response. In this way the prompt would be operationally defined as a specific number.

4. Some SAPs were judged to be practical and meaningful and based on the individual's ISP (e.g., Individual #450's count coins SAP). Several other SAPs, however, were scored as impractical because they appeared to represent compliance plans rather than skill acquisition plans (e.g., Individual #413's complete a job application SAP). Other SAPs (e.g., Individual #189's counting decorations SAP) were scoring as nonfunctional because they were not clearly related to the individual's vision statement. San Angelo SSLC should prioritize the identification of individualized, practical, functional SAPs for each individual that are critical to the achievement their ISP goals.

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: Due sustained high performance, indicator 11 will be moved to the category of requiring less oversight. Performance on indicator 10, however, decreased to 67%; details are in the comments below. Indicator 12 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 413	376	383	300	450	201	412	471	189
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	89%	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		8/9									

Comments:
10. Individual #412 had an FSA update, but did not have a completed FSA. Individual #300 and Individual #383 did not have vocational assessments.

12. Individual #413 did not have recommendations, or a rationalization why a SAP was not required for a vocational SAP.

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.

With the exiting of the outcome and indicators in restraint and psychology/behavioral health, at the start of this review, this domain contained 23 indicators that were in the category of requiring less oversight. For this review, an additional five indicators are moved to this category in the areas of psychiatry, medical, and pharmacy.

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

Goals/Objectives and Review of Progress

Justifications for polypharmacy regimens did not meet criteria. Plans for tapering, however, were shown for two-thirds of the individuals. Polypharmacy reviews were not being conducted as needed for each individual. On the positive, polypharmacy review committee included active discussion and input from the attendees.

Acute Illnesses/Occurrences

One individual in the review group was not seen by psychiatry. She did not have a Reiss screen completed or submitted. This also occurred during the last review.

Nursing assessments at the onset of signs and symptoms of acute illnesses/occurrences that are in alignment with applicable guidelines, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It was positive that in most instances reviewed, nursing staff timely notified the practitioner/physician of individuals' signs and symptoms in accordance with the nursing guidelines for notification. For the six acute illnesses/occurrences reviewed, nursing staff developed acute care plans. All of them included some of the necessary interventions, but all six were missing key interventions. Nurses thoroughly implemented two of the six acute care plans.

As indicated in previous reports, there was a continued need for improvement with regard the assessment and follow-up of acute illnesses and occurrences addressed at the Center. When individuals were transferred to the hospital, it was positive that PCPs or nurses communicated necessary clinical information with hospital staff. The related indicator will move to less oversight. It also was positive that prior to transfer, PCPs/providers completed assessments, when possible, that were consistent with generally accepted standards. Problems were noted in half of the examples reviewed with the provision of treatment provided to individuals prior to their transfer to the hospital for the acute illnesses/occurrences. PCPs also needed to attend and contribute to ISPA meetings to ensure that IDTs address follow-up medical and healthcare supports to reduce risks and allow for early recognition, as appropriate.

Implementation of Plans

Psychiatric annual and quarterly evaluations did not meet the documentation requirements. One-third of the individuals were missing at least one quarterly review.

Psychiatry clinic was observed for two providers, for a total of five quarterlies. Behavioral health, nursing, the QIDP, and direct care were present. This was good to see, but they did not participate in the overall discussion. Both psychiatrists were kind and considerate of the team. They were interested in the individuals.

The neurologist conducted regular consultations, but there was little/no collaboration with psychiatry. For instance, there was question as to whether or not medications were designated as dual purpose. Attention needs to be paid to whether medications are, or are not, being used for dual use.

There were improvements in the timely prescriber review of the MOSES/AIMS assessments.

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 a 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.

None of the nine individuals reviewed received all of the preventative care they needed, and most individuals in the review group had two or more aspects of preventative care that were overdue. Based on interview and review of documents, Center staff did not follow the State Office directive entitled: "IDT Decision-making Related to Medical and Dental Appointments during COVID-19."

For none of the nine individuals in the review group, medical practitioners 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.

Medical Department staff continue to need to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. For two of the 18 chronic or at-risk conditions reviewed, PCPs had conducted medical assessments, tests, and evaluations consistent with current standards of care, and/or identified the necessary treatment(s), interventions, and strategies, as appropriate.

With regard to non-Facility consultations, the indicators related to timely PCP review, and the completion of related IPNs in accordance with quality standards have been in less oversight since Round 14 and Round 16, respectively. However, they are at

risk of returning to active oversight due to regression noted during this review. While improvement was noted, the Center needs to continue 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.

At the time of the review, there was no dentist available to provide needed dental treatment, and the Center did not otherwise have arrangements in place to provide general dentistry services. In addition, as the Dental Director reported during the January 2021 review, no total intravenous anesthesia (TIVA) clinics were conducted since April 2020. For this review, staff reported that since the January 2021 review, only one TIVA clinic was conducted (i.e., on 6/28/21). As a result, staff reported that 10 individuals were awaiting TIVA in order to have a general evaluation. An additional 28 to 30 individuals were pending treatment with TIVA for specific procedures and treatment that were outlined in their treatment plans. The seven applicable individuals in the review group (i.e., two were edentulous) often did not receive necessary dental treatment in a timely manner.

Based on the individuals reviewed, the Clinical Pharmacist completed Quarterly Drug Regimen Reviews (QDRRs) timely, and psychiatric practitioners reviewed them timely. As a result of the Center's consistency over time, two related indicators will move to the category requiring less oversight. The quality of the QDRRs reviewed was high with continued improvement noted over the past few reviews. It also was positive that in most cases reviewed, prescribers implemented the recommendations to which they agreed.

Twenty-two out of 23 individuals observed had assistive/adaptive equipment that appeared to be the proper fit. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

It was positive that during 95% of the observations, individuals' PNMPs were implemented as written. This was good progress from the previous three reviews, when the scores ranged from 68% to 74%.

Restraints

As noted in Domain #1 of this report, the Monitor found that that the Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement, including the Center's response to frequent usage of crisis intervention restraint (i.e., more than three times in any rolling 30-day period.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
			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: Psychiatric indicators were not consistently identified, data were not appropriately presented, and there were no reliability or validity measures. This competed with the ability of the Monitoring Team to full assess indicators 8 and 9. The Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals who are not meeting treatment goals. This has been the case for a number of consecutive reviews and, therefore, indicators 10 and 11 will be moved to the category of requiring less oversight. Indicators 8 and 9 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189	
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	N/A										
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
11	Activity and/or revisions to treatment were implemented.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
Comments:												

8-9. Per a review of the individual's goals and indicators as well as available data, there was one individual who was making progress toward their treatment goals. Specifically, Individual #201 was progressing with regard to the indicator/goal for reduction. The issue was that the indicators were not consistently identified, data were not appropriately presented, and there were no reliability or validity measures regarding data. Further, the goals were not included into the overall treatment program, the IHCP.

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, environmental changes) were developed and implemented. There were individuals in the review group who were noted per their treating psychiatrist to be psychiatrically stable, however, some individuals with this designation were noted to have adjustments to their medication regimen or behavior management program.

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

Summary: Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 413	376	383	300	450	201	412	471	189
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.	13% 1/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	1/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/8	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 and the functional behavior assessment discussed the role of the psychiatric disorder upon the presentation of the target behaviors for one of the individuals in the review group receiving psychiatric services, Individual #189. For three individuals, Individual #413, Individual #300, and Individual #412, the BHA was out of date. Updated documents were requested, but not submitted for review. For Individual #376, Individual #450, Individual #201, and Individual #471, the diagnoses included in the BHA were not consistent with those documented by psychiatry.

24. Eight individuals in the review group had a PBSP. Although there was an integration tool for Individual #471, Individual #412, and Individual #450 documenting collaboration, this was confusing because diagnoses were inconsistently identified for all three individuals. Further, diagnoses were inconsistently identified for Individual #376 and Individual #201. For Individual #189, Individual #300, and Individual #413, there was no specific documentation of psychiatric participation in the development of the PBSP.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.

Summary: Attention needs to be paid to whether medications are, or are not, being used for dual use. These two indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	0% 0/2	0/1								0/1
26	Frequency was at least annual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	0% 0/2	0/1								0/1

Comments:
25-27. These indicators applied to two individuals in the review group, Individual #413 and Individual #189, but in both cases, psychiatry was inconsistent with regard to the indicators for the antiepileptic medication. For Individual #413, some of the psychiatric documentation noted that Trileptal was indicated for a dual purpose, but the indication per pharmacy and neurology was seizures. Further, although psychiatry indicated that Trileptal was not dual purpose, they completed a consent form for this medication.

Individual #189 was prescribed Ativan, per pharmacy, for seizures. Neurology consultation also indicated Ativan was indicated for seizure. Although psychiatry indicated that there were no dual-purpose medications prescribed, psychiatry submitted a consent form for Ativan, noting that it was for anxiety. The indication for this medication needs to be designated. It is even more important in this case because Individual #189 was concomitantly prescribed an opiate medication.

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

Summary: One-third of the individuals were missing at least one quarterly review. This needs to improve in order for indicator 33 to remain in the category of requiring less oversight after the next review. Quarterly review documentation did not meet criteria. Psychiatry clinics observed by the Monitoring Team did not meet criteria. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	N/A									

Comments:
33. Quarterly reviews were completed in a timely manner for six individuals requiring them.
- For Individual #376, there was a quarterly dated 10/11/21 with the next quarterly dated 3/23/21, so there was an evaluation missing in January 2021.

- For Individual #412, there was a quarterly evaluation dated 1/3/21 with the next evaluation dated 6/30/21. There should have been an evaluation in April 2021.
- For Individual #189, there was a quarterly dated 3/21/21 with the next evaluation dated 7/5/21. An evaluation was due in June 2021.

34. The Monitoring Team looks for nine components of the quarterly review. None of the examples included all the necessary components. Two evaluations were missing six elements three evaluations were missing three elements, three evaluations were missing two elements, and one evaluation was missing one element. The most common missing element was the psychiatric diagnosis with a description of symptoms that support the diagnosis, missing in all examples.

- The evaluation regarding Individual #413 was missing the pertinent laboratory examinations, the psychiatric diagnosis with a description of symptoms that support the diagnosis, and non-pharmacological interventions.
- The evaluation regarding Individual #376 was missing the most recent MOSES/AIMS results, data, and the psychiatric diagnosis with a description of symptoms that support the diagnosis.
- The evaluation regarding Individual #383 was missing data and the psychiatric diagnosis with a description of symptoms that support the diagnosis.
- The evaluation regarding Individual #300 was missing the basic information, the pertinent laboratory examinations, the most recent MOSES /AIMS results, data, the psychiatric diagnosis with a description of symptoms that support the diagnosis, and non-pharmacological interventions.
- The evaluation regarding Individual #450 was missing the basic information, the pertinent laboratory examinations, the most recent MOSES/AIMS, data, the psychiatric diagnosis with a description of symptoms that support the diagnosis, and non-pharmacological interventions.
- The evaluation regarding Individual #201 was missing data and the psychiatric diagnosis with a description of symptoms that support the diagnosis.
- The evaluation regarding Individual #412 was missing the most recent MOSES/AIMS and the psychiatric diagnosis with a description of symptoms that support the diagnosis.
- The evaluation regarding Individual #471 was missing the most recent MOSES/AIMS, data, and the psychiatric diagnosis with a description of symptoms that support the diagnosis.
- The evaluation regarding Individual #189 was missing the psychiatric diagnosis with a description of symptoms that support the diagnosis.

35. During the remote virtual monitoring visit, psychiatry clinic was observed with two providers for a total of seven individuals. None of the individuals included in the review group were evaluated in psychiatry clinic during the visit. The psychiatrists were well prepared and presented the patient to the IDT. This did not allow for the other members of the IDT to present information. While the psychiatrists asked if team members had anything to add, there was generally little to no discussion regarding the individual. Medication changes were not made as a team decision or based on data.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.												
Summary: The MOSES and AIMS assessments were completed in a timely manner, but the prescriber review of the assessments was delayed for about half of the individuals. Even so, this was an improvement from previous reviews. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	56% 5/9	1/1	0/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1

Comments:

36. The MOSES and AIMS assessments were completed in a timely manner, but the prescriber review of the assessments was delayed.
    - For Individual #376, the AIMS dated 3/12/21 was not reviewed until 5/16/21. The MOSES dated 3/12/21 was not reviewed until 7/27/21. The AIMS and MOSES dated 9/14/20 were not reviewed until 10/4/20.
    - For Individual #300, the AIMS dated 4/6/21 was not reviewed until 5/24/21.
    - For Individual #450, the AIMS and MOSES dated 5/28/21 were not reviewed until 7/27/21. The AIMS and MOSES dated 11/30/20 were not reviewed by the prescriber until 12/28/20.
    - For Individual #471, the MOSES and AIMS dated 6/16/21 were not reviewed by the prescriber until 7/27/21. The AIMS dated 4/16/21 was not reviewed until 5/23/21 and the MOSES and AIMS dated 1/14/21 were not reviewed until 2/12/21.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.												
Summary:			Individuals:									
#	Indicator	Overall Score										
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?											
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?											
Comments:												

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.												
Summary:			Individuals:									
#	Indicator	Overall Score										

40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	
42	There is a treatment program in the record of individual who receives psychiatric medication.	
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	
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: Justifications for polypharmacy regimens did not meet criteria. Plans for tapering, however, were shown for two-thirds of the individuals. Polypharmacy reviews were not being conducted as needed for each individual. On the positive, polypharmacy review committee included active discussion and input from the attendees. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 413	376	383	300	450	201	412	471	189
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	0% 0/6	0/1	0/1			0/1		0/1	0/1	0/1
45	There is a tapering plan, or rationale for why not.	67% 4/6	0/1	1/1			1/1		1/1	1/1	0/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	0% 0/6	0/1	0/1			0/1		0/1	0/1	0/1

Comments:
44. Of the 144 individuals participating in psychiatry clinic at the facility, 122 individuals or 85% were prescribed medication regimens that met the definition of polypharmacy.

These indicators applied to six individuals, Individual #413, Individual #376, Individual #450, Individual #412, Individual #471, and Individual #189. The justification for polypharmacy was not appropriately documented in any case.

45. There was a documentation for four of the six individuals who met criteria for polypharmacy showing a plan to taper a psychotropic medication or a rationale as to why this was not considered.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of regular meetings from August 2020 through September 2021. Although there was documentation of annual reviews of regimens meeting criteria for polypharmacy in some cases, there was no documentation of quarterly reviews when regimens were changed.

- There was no evidence of a review regarding Individual #189 in the last year. This may be a complication of the indication for Ativan.
- There was an annual review for Individual #471 in June 2021. Given the adjustments to her medication regimen, she met criteria for quarterly reviews.
- There was documentation of attempts to review Individual #412's regimen. The regimen was reviewed 7/28/21, with an attempt at a review documented 3/10/21. For the March 2021 review, the RNCM did not come to the meeting and they invited the wrong BHS. So, although there was an attempt at quarterly reviews, this did not occur. Given her prescribed regimen and the medication changes, she must be reviewed quarterly.
- There was no documentation of a committee review regarding Individual #450. Given the adjustments to her regimen, she should be reviewed quarterly.
- Individual #376 was last reviewed by the committee in October 2020. Given the adjustments to his regimen, he should be reviewed quarterly.
- There was no documentation of a review regarding Individual #413. This may be a complication of the confusion regarding the indication for Trileptal.

The polypharmacy committee meeting was observed by the Monitoring Team when it occurred the week after the remote virtual monitoring review week. The prescribing psychiatric clinician presented the medication regimens for individuals during the meeting with other information including laboratory examinations and data discussed. Overall, the meeting was comprehensive and included discussion regarding the regimens, including plans to taper some medication. The pharmacist took the lead in facilitating discussion. 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

At a previous review, the Monitor found that that the Center achieved and maintained substantial compliance with the requirements of section K of the Settlement Agreement and, as a result, was exited from section K of the Settlement Agreement.

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.
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

Outcome 4 – Individuals receive preventative care.

Summary: None of the nine individuals reviewed received all of the preventative care they needed, and most individuals in the review group had two or more aspects of preventative care that were overdue. Based on interview and review of documents, Center staff did not follow the State Office directive entitled: "IDT Decision-making Related to Medical and Dental Appointments during COVID-19."

For none of the nine individuals in the review group, medical practitioners 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. This is an area that needs improvement.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	67% 2/3	N/A	N/A	0/1	1/1	N/A	N/A	N/A	N/A	1/1
	iii. Breast cancer screening	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
	iv. Vision screen	44% 4/9	1/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1
	v. Hearing screen	13% 1/3	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/R	1/1
	vi. Osteoporosis	38% 3/8	1/1	0/1	0/1	0/1	0/1	N/A	1/1	0/1	1/1
	vii. Cervical cancer screening	50% 2/4	N/A	0/1	1/1	N/A	N/A	N/A	1/1	0/1	N/A

b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. On 9/17/21, after the remote review, State Office submitted a chart to the Monitors entitled: "Current San Angelo Tracking Activities on Hold 09 2021." With regard to preventive care, this chart included information that was inconsistent with other information that State Office has provided to the Lead Monitor. According to the chart, on 3/16/20, routine preventive care was put on hold, and the chart indicated that it had not been reinstated. The column for "Facility Comments" stated: "Continue to only provide off-campus consultations for 'Essential' medical needs, and the Interdisciplinary Team must produce an Individual Support Plan Addendum." The meaning of this was unclear. A second row indicated that on 3/16/20, the Center implemented no off-campus appointments unless emergent, and noted that these services were reinstated on 5/27/20, with a comment that: "Emergency Room visits and hospitalizations are allowed if necessary." These comments were confusing. For example, by definition, emergency room visits are necessary in the case of acute care issues that cannot be addressed at the Center.

The re-initiation date (or lack thereof) for off-campus appointments that the Center/State Office included on this chart was inconsistent with guidance State Office provided to the Centers regarding off-campus appointments for medical and dental care. More specifically, at the Lead Monitor's request, one of the Centers provided a copy of the State Office directive, dated 5/27/20, entitled: "IDT Decision-making Related to Medical and Dental Appointments during COVID-19." This directive instructed IDTs to "use a deliberate decision-making process to determine whether an individual should be scheduled to attend an off-site medical or dental appointment. The risk of exposure to COVID-19 and the Individual's level of risk should they contract the virus must be balanced with the level of urgency to the scheduled consult or procedure and the risk to the individual if treatment is delayed. The IDT should prioritize appointments based on the risk of delaying the appointment and should postpone the scheduling of any routine or non-urgent appointments, as appropriate. The Primary Care Provider and/or dental professional must be in attendance to the ISPA…" The directive identified factors for consideration when no options were available to provide the needed medical or dental service on campus, including, but not limited to: "The potential impact on the individual's overall health should an existing condition worsen, or a new condition go undetected due to delaying a screening… Whether the risks related to completion of the screening or procedure outweigh the risk of delay." Based on this directive, beginning on 5/27/20, off-campus appointments could occur, and IDTs had the responsibility to weigh the risks/benefits of delaying or moving forward with necessary preventive care and screenings (as well as other medical care and treatment). In addition, the chart appeared inaccurate in that individuals in the review group had received some preventative care since 5/27/20.

During the Monitoring Team's interview with the Medical Director, the State Office Discipline Lead for Medical stated that individuals who were vaccinated could participate in off-campus appointments, but that the team process described above was still in place for unvaccinated individuals. The Lead Monitor requested documentation to show communication of this change from State Office to the Center, and from Center administration to the PCPs and the IDTs. The State Office and Center responses indicated that written communication was not available.

Given all of these inconsistencies, in scoring this section, the Monitoring Team relied on the written guidance that State Office issued on 5/27/20. This appeared to be the last written guidance on the topic.

In its Tier II document request, the Monitoring Team specifically asked for: "For any preventative care not completed due to COVID-19 precautions, please provide the ISPA showing the IDT risk-benefit discussion." For the nine individuals in the review group, Center staff submitted no ISPAs in response to this request. As the findings below illustrate, many of the individuals reviewed had overdue preventive care. It will be essential moving forward that staff follow the State Office procedure, including any updates to the procedure issued on 5/57/20, and reschedule individuals for these services as soon as possible.

The following provide examples of findings:

- On 6/22/16, Individual #189's last audiology evaluation showed "probably normal hearing." On 1/24/21, the PCP requested an audiology evaluation. According to the Medical Director, at the time of the Monitoring Team's review, it had not yet been done.
- For Individual #412:
    - Although a note indicated that on 3/29/21, the individual had an audiology consultation, and there were "no concerns of hearing," no audiology report was submitted. During interview, the PCP reported that the audiologist did not submit a report. The 2020 AMA did not document a hearing assessment.
    - Center staff submitted no information about the individual's cervical cancer screening. The AMA stated a screening was scheduled for 9/23/20. According to the PCP, in November 2020 and January 2021, the individual refused. In August 2021, it was reordered. According to the Medical Director, the individual's last screening was in July 2016.
    - In June 2021, a DEXA scan was ordered due to the prescription of Divalproex and Depo-Provera, which increase the risk for loss of bone mineral density (BMD). At the time of the review, the scan had not been completed.
- For Individual #137:
    - In mid-January 2021, she was diagnosed with COVID-19 disease and was hospitalized. On 2/4/21, she received the COVID-19 vaccination. This administration of the vaccine appeared inconsistent with the Center for Disease Control (CDC) guidelines, and was a possible medication variance.
    - On 10/7/09, a gastroenterology (GI) consultant made a recommendation to perform stool testing, and if any were positive, an attempt should be made to complete a barium enema to look at the right colon. On 1/27/21, the Medical Director documented a lab result review which stated: "FIT [fecal immunochemical] test was performed by [nurse's name], RN and reported as negative." According to the State Office Discipline Lead for Medical, the Centers do not have the capability to perform Point of Care FIT testing. The actual report of stool testing was not submitted. As discussed during interview with the PCP and State Office representatives, this result was likely a guaiac stool fecal occult blood (FOB) test. A single guaiac stool test is not an acceptable form of colorectal cancer screening per State Office guidelines.
    - On 6/11/20, the individual had a vision exam, with a recommendation to return in six months. Documentation of further follow-up was not submitted.
    - In response to the document request, Center staff submitted no information about an audiological/hearing screening. According to the AMA, on 2/1/18, an audiology evaluation was done and showed hearing within normal limits. The recommendation was to repeat a screening in February 2019, but none was submitted. The AMA's physical exam section did not include a hearing assessment.
    - On 9/6/18, a DEXA scan showed osteopenia. Per State Office guidelines, the individual should have had a repeat DEXA in two to three years. The PCP reported that on 9/15/21 (i.e., the week of the remote review), the DEXA was ordered.

- For Individual #203:
  - No audiology report was submitted. The AMA indicated that on 3/2/21, an audiology assessment was ordered. According to the Medical Director, it had not been completed.
  - On 9/10/20, a DEXA scan was attempted, but due to the individual's lack of cooperation, it could not be completed. On 3/2/21, another was ordered, but not yet completed.
  - On 11/30/18, the individual had a vision assessment with a diagnosis of macular degeneration. The recommendation was for her to return in one year. No follow-up was submitted.
- For Individual 410, who was admitted in 2018:
  - With regard to a vision screening, Center staff submitted no documentation, and based on interview with the PCP, no documentation was found of any eye evaluation in the records. On 7/21/21, the PCP re-ordered it. During the interview, the PCP reported that there was no pending appointment.
  - Similarly, the individual had not had a hearing screening since his admission. On 7/21/21, the PCP also reordered this screening.
  - In the QDRR, dated 4/6/21, the Clinical Pharmacist recommended a DEXA scan due to anti-epileptic drug (AED) use. In July 2021, the PCP ordered a DEXA, but at the time of the review, one had not been completed.
- For Individual #247:
  - On 3/9/20, according to a hand-written report of his audiological assessment, the individual reported decreased hearing in his left ear and left the booth. During interview, the PCP commented that it appeared the evaluation was not completed. Additionally, according to the AMA's documentation of the physical examination, the individual had decreased hearing in the left ear using the whisper test. There was no documentation of follow-up testing.
  - On 8/2/19, he had a vision screening with a recommendation to return in two years. According to the PCP, it was ordered the day prior to the interview with the Monitoring Team (i.e., 9/15/21).
- For Individual #429:
  - The 2016 audiology report stated: "Could not be seen due to equipment failure." The PCP reported that in January 2021, an audiology evaluation was ordered, and in June 2021, it was re-ordered. It had not yet been completed.
- For Individual #319:
  - Reportedly, during the week of the remote review, an audiological assessment was completed. The Monitoring Team did not rate this sub-indicator, because a report was not available for review.
  - Reportedly, on 3/27/20, the individual had cervical cancer screening. No documentation was submitted, even though the Monitoring Team asked for it in the original Tier II request. In addition, during the interview, the Monitoring Team again asked that Center staff submit it in response to the original Tier II request. Center staff submitted an IPN, but not a pap report.
  - Based on the Center's response to the Monitoring Team's Tier II request, this individual did not require a DEXA scan. However, in the AMA, a provider documented a DEXA was ordered even though she did not meet inclusion criteria. On 4/7/21, in the QDRR, the Pharmacist made a recommendation for a DEXA due to medication use. Reportedly, it was done on 9/8/21, but the PCP did not process it. During the interview, the Monitoring Team asked that Center staff submit it in response to the original Tier II request. Center staff submitted an IPN, but not a DEXA report .

- On 3/13/20, Individual #343 had a vision exam, with a recommendation to return in three months. He was prescribed medications that placed him at high risk. In August 2021, the PCP put in two orders, but the appointment had not yet been completed. At the time of the remote review, an active order was pending from 8/10/21.

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.

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.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	100% 2/2	1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A

Comments: a. For the two individuals in the review group with out-of-hospital DNRs in place, documentation showed that they had conditions that justified the orders in alignment with State Office policy.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

Summary: As indicated in previous reports, there was a continued need for improvement with regard the assessment and follow-up of acute illnesses and occurrences addressed at the Center. Given that over time, PCPs or nurses communicated necessary clinical information with hospital staff (Round 14 - 80%, Round 15 – 71%, Round 16 – 100%, and Round 17 - 100%, Indicator f will move to the category requiring less oversight. It was positive that for the acute events requiring an ED visit or hospitalizations that the Monitoring Team reviewed, PCPs/providers completed assessments, when possible, that were consistent with generally accepted standards. Problems were noted in half of the examples reviewed with the provision of treatment for the acute illnesses/occurrences. PCPs also needed to attend and contribute to ISPA meetings to ensure that IDTs addressed follow-up medical and healthcare supports to reduce risks and allow for early recognition, as appropriate. The remaining indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
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.	8% 1/13	0/1	0/2	0/2	0/1	0/1	0/2	0/1	1/2	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.	31% 4/13	0/1	1/2	0/2	0/1	0/1	0/2	1/1	2/2	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, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 4/4	2/2	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 2/2	1/1		N/A		1/1				
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	50% 2/4	1/2		0/1		1/1				
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 4/4	2/2		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.	0% 0/3	0/2		0/1		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.	75% 3/4	2/2		1/1		0/1				
Comments: a. For the nine individuals in the review group, the Monitoring Team reviewed 13 acute illnesses/occurrences addressed at the Center, including: Individual #189 [deep vein thrombosis (DVT) on 5/12/21], Individual #412 (nasal fracture on 2/2/21, and human bite on 3/8/21), Individual #137 (syncope on 7/7/21, and herpes on 7/13/21), Individual #203 (pressure ulcer on 4/27/21), Individual #410 (laceration on 7/16/21), Individual #247 (choking on 4/19/21, and groin pain on 4/13/21), Individual #429											

(hidradenitis suppurativa on 8/10/21), Individual #319 (paronychia on 3/18/21, and cellulitis on 4/16/21), and Individual #343 (thumb laceration and herpes labialis on 4/12/21).

The PCP assessed the following acute issue according to accepted clinical practice: Individual #319 (paronychia on 3/18/21).

b. For the following, the PCPs conducted follow-up assessments and documentation at a frequency consistent with the individuals' status and the presenting problems until the acute problems resolved or stabilized: Individual #412 (human bite on 3/8/21), Individual #429 (hidradenitis suppurativa on 8/10/21), and Individual #319 (paronychia on 3/18/21, and cellulitis on 4/16/21).

The following provide examples of concerns noted:

- On 5/12/21, nursing staff documented that a direct support professional staff reported that Individual #189's "left leg is really swollen." Per nursing documentation, the individual's blood pressure was 163/93, "but this is not unusual" for the individual. There was swelling "from mid-thigh to lower leg." According to nursing documentation, the Medical Director was notified and ordered a chest x-ray and labs that were to be done stat at the hospital. The documentation also stated that the Medical Director would assess the individual at home. In the records submitted, on 5/12/21, or 5/13/21, there was no documentation of assessment by a medical provider.

  On 5/13/21, nursing staff documented the stat labs returned with abnormal results. The nurse contacted another PCP regarding the results, and per nursing documentation, that PCP "was unaware of labs and or any follow-up [sic] needed." Nursing staff further documented that the Medical Director was notified, and "confirmed results were known and were less than previous labs."

  On 5/14/21, the PCP documented an assessment stating he was called to evaluate the individual due to "malaise and bilateral leg edema." This was the first documentation of an assessment by a medical provider. The physical exam was pertinent for an individual that was "a bit lethargic and distracted." There was 3+ edema of left lower extremity (LLE) and 2+ edema of the right lower extremity (RLE). The provider did not document pulses, skin temperature, or color.

  The ultrasound of the lower extremity, completed on 5/14/21, showed "diffuse thrombosis of left common femoral, superficial femoral and popliteal vein." The plan was to start Xarelto, elevate leg, and diurese. The exact date that the ultrasound was ordered was not clear due to a lack of documentation by the medical provider on 5/12/21, and 5/13/13. Nevertheless, it was clear that the diagnosis of "diffuse thrombosis" was made two days after nursing staff reported significant leg swelling.
- On 2/2/21, Individual #412 was involved in a peer-to-peer altercation and sustained an injury to her nose. Nursing staff documented that nasal swelling and a small amount of bleeding were present. The nurse notified the PCP. The Center did not submit any IPN documentation of an exam immediately surrounding the injury. On 2/9/21, the PCP documented the x-ray findings of a minimally displaced nasal fracture with rightward convex nasal septal deviation.

  On 2/10/21, the Medical Director wrote a note that stated that on 2/2/21, the individual sustained nasal trauma and had "some swelling over the bridge of nose with associated mild rightward septal deviation. She was seen in the clinic the next day." On 2/2/21, or 2/3/21, there was no documentation of an exam by a medical provider. Moreover, on 2/10/21, the IPN

documentation also did not include a physical examination. An expedited ear, nose, and throat (ENT) consult was requested. There was no additional follow-up by the PCP. On 2/26/21, the ENT evaluation was completed at which time the individual was diagnosed with a non-displaced nasal fracture that required no further treatment.

Nasal fractures may be associated with other facial injuries, and, therefore, a thorough exam of the face is necessary. The exam of the nose should include palpation for tenderness, crepitus, and abnormal movement. The septum should be inspected for signs of trauma, including a septal hematoma that requires immediate attention.

- On 3/18/21, the PCP documented seeing the Individual #412 due to a human bite. The individual was involved in a peer-to-peer altercation, and another individual bit her. The PCP documented performing a focused exam of the left forearm. "There is a circular open wound on her left mid forearm with tooth marks on it. The epidermis has been lacerated. The wound may be 2 inches in circumference with teeth marks all around it. No bleeding noted."

  The assessment was left forearm human bite, and the plan was to provide local wound care and antibiotics with follow-up in seven days. The PCP did not address the tetanus, human immunodeficiency virus (HIV), or hepatitis status for the individual.

  On 3/25/21, the PCP documented mostly healed bite marks with no redness or swelling. The plan was to complete antibiotics.
- On 7/7/21, the PCP documented that at around 8:15 a.m., Individual #137 had a brief episode of syncope while riding in a golf cart. The PCP noted the individual had "syncope of undetermined origin," and was back to baseline status. There was no cardiac exam documented. There was no plan of care to address the etiology of the syncopal episode. The PCP also noted that at around 3:30 p.m., she was informed that the individual had brown emesis that was negative for occult blood. The plan was to monitor. There was no follow-up by the PCP.

  On 7/16/21, the neurologist saw the individual. With regard to the syncopal episode he noted: "I find no records that she went to the emergency room with that episode." His assessment was a "single brief episode of loss of consciousness on 7/07/2021 of unknown clear etiology." The neurology plan included obtaining lab work, including a troponin level and an electrocardiogram (EKG). He also requested an electroencephalogram (EEG). The PCP did not document the outcome of the evaluation.
- On 7/13/21, nursing staff documented that Individual #137 had a red area with a three-centimeter (cm) sore to her lower right lip. The plan was to notify the PCP if a cream was needed. On 7/15/21, the PCP documented: "Alerted to lesion of pts lower lip by CM…, RN/ No known history of HSV [herpes simplex virus] however picture reveals cluster of 2-4mm vesicles with associated underlying erythema, classic picture of HSV." Oral valacyclovir and acyclovir ointment were prescribed. There was no assessment by the PCP in the notes submitted and no documentation of follow-up.
- On 4/27/21, the Medical Director documented: "PNMT RN reports that [Individual #203] has developed recurrent swelling and discoloration of her right great toe. I have referred her back to Wound Care Specialist for management."

  This individual had a history of a Stage 3 pressure ulcer in February 2021. Per PNMT documentation on 4/27/21, the wound was unstageable. On 5/5/21, a wound care specialist evaluated the individual, and the diagnosis was open wound of right great toe and unstageable pressure ulcer of other site. There was no documentary evidence, in the records submitted, that a medical provider at the Center ever assessed the wound for this individual with a recurrent pressure ulcer.

- On 7/16/21, nursing staff documented that Individual #410 sustained a wound to his left hand after punching a TV. The nurse documented a small bleeding wound. The nurse contacted the PCP, but based on documentation submitted, there was no medical assessment of the wound.

  On 7/18/21, at 2:53 a.m., nursing staff documented that the "periwound" was red and edematous. The PCP asked for a nursing assessment, and for the individual to be placed on the sick call list for 7/19/21. There was no documentation of a medical evaluation on 7/18/21. On 7/18/21, at 6:37 p.m., nursing staff documented that the wound was macerated with white-grey color, and the individual reported some bleeding earlier.

  On 7/19/21, the PCP documented that the individual injured his finger "this weekend" when he punched his TV and caused a superficial cut over the proximal inter-phalangeal (PIP) joint of the left 5th digit. At the time of evaluation, the PCP noted that the wound was more than 48 hours old, and the individual was not a candidate for sutures or Dermabond. The PNMT nurse assessed the wound and provided wound care.

  On 7/23/21, the PCP assessed the individual due to reports of a possible infection. The PCP documented that the 5th digit was swollen up to the knuckle. There was warmth, redness, tenderness, and an effusion present. The individual was unable to bend the finger. Antibiotics were started with a plan to follow up in three days. On 7/27/21, the PCP documented that the wound was healing. It was noted that he "lacks some extension like his middle finger." The significance of that statement was not clear, and there was no documentation of full testing of the extension of the finger given the laceration was over the extensor surface of the digit. There was also no follow-up to determine if he regained full extension.
- On 4/19/21, nursing documented that at around 8:00 a.m., Individual #247 experienced a choking incident while eating in the dining room. Staff had to administer abdominal thrusts to clear the obstruction. Per nursing documentation, the Medical Director, SLP, Campus Coordinator, and Administrator were notified. In the records submitted, there was no documentation that a medical provider examined the individual, addressed the etiology of the choking incident, or developed a plan of care to address supports that were needed.

  On 6/19/21, the PCP documented that he was notified of another choking incident. It was noted that the individual's diet was downgraded, and the aspiration protocol was implemented.

  On 6/21/21, which was two days after the individual choked, the Medical Director assessed the individual. It was noted that this was the second choking incident. Per medical documentation, the changes in diet were discontinued because the bedside swallow study done by the SLP was normal. The plan was to order a baseline MBSS. The SLP recommended additional training and education. The individual was scheduled to have a tooth extraction later that day. The Medical Director indicated no further treatment was indicated. However, there was no documentation related to the outcome of the MBSS that the Medical Director ordered.
- On 4/13/21, Individual #247 reported abdominal pain. The PCP saw him, and documented that the individual complained of left genital pain, which he associated with lifting heavy boxes a few days earlier. The PCP's assessment was groin pain, possible groin strain. The PCP prescribed the individual 600 milligrams (mg) of ibuprofen every six hours. There was no discussion of the risk associated with the use of a high-dose non-steroidal anti-inflammatory drug (NSAID) in an individual treated with

lithium. The PCP recommended warm packs and light activity with follow-up as needed. The PCP documented an examination of the groin, but did not specify if the actual genitalia were examined to determine the presence of other pathology.

On 4/15/21, nursing staff documented that the individual complained of worsening pain. He was referred to the clinic for follow-up, but there was no documentation of follow-up by a provider until 4/20/21. At that time, the provider documented the individual's complaint of increasing pain that was not relieved with ibuprofen. The exam revealed "distinct distention of the Abdomen" with moderate left lower quadrant (LLQ) tenderness. The assessment was rule out kidney stones, infection, constipation, and early acute abdomen. The plan included bedrest, clear liquids, labs, and abdominal x-rays. The ibuprofen was discontinued. The differential diagnosis included rule out (R/O) early acute abdomen.

There was no documentation that a provider completed a follow-up abdominal exam. Serial examination is essential to assessing the diagnosis of "R/O Early Acute Abdomen."

- On 8/10/21, Individual #429 was seen for "management of recurrent painful lesion of her left axilla." The assessment was hidradenitis suppurativa. The plan was to treat it with antibiotics, apply warm compresses, prescribe hydrocodone, and follow up in one week. There was no discussion of the use of opioids in an individual who was prescribed benzodiazepines. On 8/17/21, the Medical Director documented that the condition was essentially resolved.
- On 4/12/21, Individual #343's PCP documented an Acute Care Progress note that was not in subjective, objective, assessment, and plan (SOAP) format. The note was three lines and stated that: "At physical individual seen to have wide cut left thumb, dermabonded, serious injury called to incident management and administration. At physical individual seen to have a vertical cut lower lip, scabbed, herpes labialis, valacyclovir 1000mg po BID [by mouth twice a day] x 1 day. Follow-up PCP."

  There was no further description of either of the acute medical problems or a complete plan of care. There was no plan to address the wound. The note did not provide any further information of the characteristics of the wound or herpes labialis. The timeframe for follow-up was not specified.

  On 4/13/21, another PCP documented follow-up. The PCP noted that the Dermabond had washed off. The PCP described a laceration "to the distal crease below thumb." The plan was to keep the individual's thumb clean and dry, apply dressing, and treat herpes with zovirax cream. Follow-up was to occur the next week.

  On 4/22/21, a provider documented that the wound was healed. There was no further assessment of the herpes.

c. For three of the nine individuals reviewed, the Monitoring Team reviewed four acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #189 [hospitalization for DVT and sepsis on 5/15/21, and hospitalization for elevated B-type natriuretic peptide (BNP) on 7/4/21], Individual #137 (hospitalization for aspiration pneumonia on 5/3/21), and Individual #410 (ED visit for paraphimosis).

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

- On 5/15/21, Individual #189 was admitted to the hospital with the diagnoses of DVT, gram negative sepsis, and pyelonephritis. On 5/21/21, he returned to the Center, and the PCP saw him. Per PCP documentation, hospital recommendations included GI

follow-up for chronic blood loss, potential esophagogastroduodenoscopy (EGD)/colonoscopy, and referral to dentist. The PCP did not state the reason for the dental referral. Hospital records noted the presence of a tooth abscess.

On 5/22/21, and 5/23/21, the PCP evaluated the individual again and the plan was to continue current treatment. On 5/25/21, the PCP commented that the individual had a limited exam due to the need for using a Hoyer lift for placing him in bed. The PCP did not document any discussion of the risk of using a direct oral anticoagulant (DOAC) in an individual with a known history of gastrointestinal blood loss. Moreover, there was no discussion of other options to prevent the development of a pulmonary embolus in an individual at risk for GI bleeding. The Center did not submit a post-hospital ISPA for review to determine if the IDT was aware of this risk or alternative treatment options.

- On 7/4/21, the Medical Director documented that Individual #189 had a five-fold increase in BNP between 1/5/21 and 6/30/21. Additionally, the individual's weight increased from 78.74 kilograms (kg) to 93.8 kg. There was no clear clinical diagnosis documented. In a separate IPN entry on the same day, the PCP cited findings from the literature regarding the possibility that hyperthyroidism may elevate the BNP in the absence of heart failure. However, there was no documentation of a physical examination of the individual to determine if the exam and clinical findings were consistent with heart failure.

  On 7/12/21, a PCP documented the results of a chest x-ray completed on 7/8/21. Per PCP documentation, the chest x-ray showed cardiomegaly, pulmonary venous congestion, and interstitial pulmonary edema. The PCP's note documented "Correlate clinically for cardiogenic pulmonary edema." Until 7/13/21, there was no documentary evidence that a medical provider took the steps necessary to assess the individual's clinical status or clinically correlate lab and radiographic findings. Overall, timely treatment was not provided. There should have been an exam when the labs and the x-ray returned with abnormal findings.

  On 7/13/21, the Medical Director documented that the individual was evaluated, and his speech was barely comprehensible. The PCP further noted that the 7/8/21 chest x-ray was "c/w [consistent with] frank cardiac decompensation." The individual also had documented hypoxia, and, therefore, was transferred to the ED for evaluation of heart failure. He was admitted to the hospital and returned to the Center on 7/15/21. The PCP documented follow-up, and noted that the individual refused physical examination. The diagnosis was not clear in the PCP documentation. The PCP's plan was to treat the elevations of blood pressure with clonidine, increase the metoprolol, and repeat the thyroid function tests (TFTs). On 7/16/21, and 7/17/21, the PCP saw him again.

  Although the IDT held a post-hospitalization ISPA meeting on 7/20/21, the PCP did not participate to clarify the diagnosis with the IDT. This was necessary to assist the IDT in reviewing and revising his plans of care. The ISPA cited a diagnosis of heart failure.
- On 5/3/21, nursing staff documented that at around 6:40 a.m., Individual #137 experienced emesis. Nursing staff further documented: "At this time I do hear wheezing in her upper lungs, front." At 2:21 p.m., nursing staff documented that staff reported the individual was having trouble breathing. The individual was reported to have "an acetone/sweet smell to her breath." The capillary blood glucose was 198. The nurse notified the PCP who gave orders to administer a breathing treatment. Per nursing documentation, the PCP also gave orders to bring the individual to the clinic if there was no improvement with the nebulizer treatment. There was no documentation of an evaluation by a medical provider.

On 5/6/21, nursing documentation stated that the individual "wasn't acting like her normal self, much less communication, staring, not telling staff she needed to use the bathroom resulting in soling herself, and never asking for gum which is a usually near constant request. Resident reports she feels fine." The individual was also hypoxic, and had crackles in her lungs. The nurse notified the PCP, and the individual was transferred to the ED.

In a transfer note on 5/6/21, at 5:26 p.m., the PCP documented giving orders on 5/3/21, to bring the individual to the clinic. However, per the PCP, the individual was being brought to the clinic when "the order was cancelled by another nurse." The individual was transferred to the ED for further evaluation. She was hospitalized, and on 5/11/21, the individual returned to the Center.

On 5/12/21, at around 10:00 a.m., the PCP documented a post-hospital assessment. The assessment was aspiration pneumonia, fungal dermatitis, and constipation. The plan of care did not sufficiently address the diagnosis of aspiration pneumonia, and the individual's risk for recurrence which included dysphagia, gastroparesis, and food-seeking behaviors.

On 5/12/21, at 2:57 p.m., the PCP documented a Day 1 Posthospitalization Note. This was a brief note. The plan was to give a care management order, and for nursing staff to call back if magnesium citrate did not result in a bowel movement.

On 5/13/21, the PCP documented the individual was doing well per nursing staff, but was still constipated. "I had ordered a dose of MOM [milk of magnesia] on arrival from the hospital the day before yesterday. Not known if this was done at all. Not known if my orders from yesterday were followed." Vital signs were documented, but there was no documentation that the PCP actually evaluated the individual. The assessment was constipation, and the plan was to give a bottle of mag citrate. There was no discussion of the diagnosis of aspiration pneumonia or the supports to address the diagnosis. On 5/14/21, the PCP documented the individual was not in a good mood. A brief exam was documented. The assessment was resolving right pneumonia, resolved hypoxia, and resolved constipation. The PCP provided no plan of care for further mitigation of aspiration risk.

On 5/18/21, the IDT held an ISPA meeting. The RNCM attended and documented that the PCP needed to address some issues.

- On 6/18/21, nursing staff documented at 5:15 p.m.: "RN notified by LVN at 1700 that [Individual #410] had swelling, redness, and 'bumos' to his penis… [the individual] states it hurts to urinate but was able to give a sample for dipstick." The nurse notified the PCP who evaluated the individual. The assessment was balanitis, and the plan was to apply clotrimazole cream, screen for sexually transmitted infections (STIs), and report any signs of phimosis. On 6/19/21, the individual was evaluated again. At 11:26 a.m., the PCP documented that the individual had a diagnosis of balanoposthitis and would be treated with Depo Medrol, Amoxil, and warm compresses. On 6/20/21, the PCP evaluated the individual and transferred him to the ED for further evaluation.

On 6/21/21, the Medical Director evaluated the individual for severe balanoposthitis with paraphimosis, and documented: "Paraphimosis is an urgent urological condition which may require surgical release." The Medical Director contacted the office of the urologist and arranged for an appointment the following day with the understanding that should the swelling or pain

increase or cyanosis develop, the individual would need transfer to the ED. There was no documentation that the PCP attempted to reduce the paraphimosis. On 6/22/21, the urologist saw the individual who manually reduced the paraphimosis in the office. On 7/29/21, the individual underwent circumcision. There was no follow-up documented by a medical provider.

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

Summary: Indicators b and c have been in less oversight since Round 14 and Round 16, respectively. However, they are at risk of returning to active oversight due to regression noted during this review.

While improvement was noted, the Center needs to continue to focus on ensuring that PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight. However, due to regression noted during this review, Indicators b and c are at risk of returning to active oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.										
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.										
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.										
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	67% 2/3	N/A	1/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments: For the nine individuals in the review group, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #189 for cardiology on 6/25/21, and neurology on 5/7/21; Individual #412 for orthopedics on 6/3/21, and orthopedics on 7/8/21, Individual #137 for neurology on 7/16/21, and neurology on 3/19/21; Individual #203 for neurology on 3/5/21, and wound care on 5/5/21; Individual #410 for genitourinary on 6/22/21, and genitourinary on 8/13/21; Individual #247 for podiatry on 3/5/21, and neurology on 6/8/21; Individual #429 for ophthalmology on 3/8/21, and podiatry on 8/6/21; Individual #319 for ophthalmology on 3/26/21, and podiatry on 8/6/21; and Individual #343 for neurosurgery on 7/13/21, and neurology on 5/13/21.

b. and c. Indicators b and c have been in less oversight since Round 14 and Round 16, respectively. However, they are at risk of returning to active oversight. For this review, Center staff submitted no related IPNs for Individual #203's wound care consultation on

5/5/21, or Individual #247's podiatry consultation on 3/5/21. For the following consultations, PCPs did not conduct and/or document reviews within five days: Individual #412 for orthopedics on 6/3/21 (i.e., report received on 6/7/21, but review not completed until 6/18/21), Individual #137 for neurology on 3/19/21 (i.e., report received on 4/1/21, but review not completed until 4/21/21), and Individual #247 for neurology on 6/8/21 (i.e., report received on 6/9/21, but review not completed until 8/10/21). In addition, in the IPN for Individual #319 for ophthalmology on 3/26/21, the PCP did not summarize the findings or state the significance of the results.

e. With regard to referrals to the IDT and meetings to discuss and develop plans as needed:

- It was positive that the PCP made a referral to the IDT following Individual #412's orthopedics consultation on 7/8/21 due to the need to encourage her to wear the boot until the fracture was healed. However, a similar referral should have been made following the consultation on 6/3/21. Based on the individual's behavioral issues, the PCP should have made a referral to the IDT for review and to ensure that the IDT identified and implemented supports to assist the individual to comply with the treatment plan. Subsequent notes indicated that the individual was not compliant with her treatment of wearing an ace wrap and walking boot.
- It was positive that the PCP made a referral for the IDT to review the recommendations from Individual #410's genitourinary consultation on 6/22/21.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.

Summary: Medical Department staff continue to need to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. For two of the 18 chronic or at-risk conditions reviewed, PCPs had conducted medical assessments, tests, and evaluations consistent with current standards of care, and/or identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
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	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #189 – diabetes, and abdominal aortic aneurysm; Individual #412 – osteoarthritis, and hypertension; Individual #137 – CKD, and osteoporosis; Individual #203 – seizures, and sarcoidosis; Individual #410 – osteoporosis, and partial complex and pseudo seizures; Individual #247 – tobacco dependence, and dystonia; Individual #429 – respiratory compromise/asthma, and weight; Individual #319 – tobacco use disorder, and constipation/bowel obstruction; and Individual #343 – nicotine dependence, and colon polyps).

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 PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #247 – dystonia, and Individual #343 – colon polyps.

The Center used a template that listed problem/risk area, past year's supports, next year's supports, and goals. The Medical Director reported during interview that this was the section where the assessment and plan would be discussed. Previous reports have documented the deficiencies that resulted from the failure to provide a concise assessment and plan.

The following provide examples of concerns noted:

- According to the AMA, Individual #189 was diagnosed with Type 2 diabetes mellitus (T2DM). The past year's summary was the equivalent of the assessment. The summary documented that the individual was treated with metformin, which was discontinued due to A1cs that were below 7.0.

  The goal was for the individual to have a normal value A1c. The timeframe to achieve this goal was not stated. The plan listed "tasks necessary to accomplish this goal," which included considering the use of empagliflozin. The plan also included continuing the use of losartan, annual eye exams, an annual podiatry exam, annual A1cs, urinalysis (UA), albumin/creatine ratio, complete blood count (CBC), and a comprehensive metabolic panel (CMP). An annual A1c would not be frequent enough monitoring for an individual with diabetes or prediabetes.

  The summary provided no information about the current status of the individual. In other words, the plan stated what should be done, but the summary provided no information or results regarding what had already been done. Relevant information, as required by the State Office AMA guidelines, would include discussion of the presence or absence of target organ damage.
- According to the cardiology consult dated 6/25/21, during a recent hospitalization, Individual #189 was diagnosed with an abdominal aortic aneurysm (AAA). The PCP's IPN, dated 7/1/21, acknowledged the diagnosis of the AAA and stated surveillance would continue. However, the PCP did not specify a plan of care for the medical management of the AAA. Additionally, hospital records, dated 5/16/21, indicated that there was an aneurysm of the thoracic aorta and not the abdominal aorta.

  During discussion with the Medical Director, the Monitoring Team member asked questions about the AMA's documentation that the individual smoked a pack of cigarettes daily. The Medical Director responded that the individual was no longer smoking and had a DNR order in place. However, the individual's DNR status was implemented on 4/21/20. Therefore, the individual would have qualified for smoking-related screenings related to lung cancer and AAA several years prior to the implementation of the DNR order.

  The IMR, completed on 6/25/21, did not document the diagnosis of a thoracic aneurysm, nor did it include a plan for management of the condition.

  The Change of Status (CoS) IHCP documented a blood pressure goal of <180/110. Appropriate management of hypertension is a fundamental principle in the management of AAA and thoracic aneurysms. There was no explanation for setting this blood pressure goal.
- The assessment and plan component of the AMA discussed Individual #412's osteoporosis, falls/fractures, osteoarthritis, and Vitamin D deficiency as one problem. The diagnosis of osteoarthritis was not discussed. Under the discussion of risk factor

ratings, the PCP documented that the individual had a diagnosis of osteoarthritis that caused pain, swelling, and reduced joint motion. There was little clarity about the diagnosis since the PCP did not specify which joints were involved and there was no medical plan of care.

The management of osteoarthritis was a significant issue for this individual. The IMR, dated 6/28/21, documented that the individual had an 8% weight gain. During interview, the PCP reported that knee pain impacted the individual's ability to exercise. However, the medical plan provided no specific information on the treatment plan.

The history regarding osteoarthritis should note the duration of symptoms, morning stiffness, medication trials, impact of exercise, family history, injuries, and the presence of systemic symptoms. The physical exam of the knee should include the presence or absence of swelling, warmth, tenderness, crepitus, and range-of-motion (ROM). Such examination should be included as part of a basic physical exam.

During interview, the PCP acknowledged that the AMA included no specific examination of the knee. The individual had significant degenerative changes on x-ray. According to the Medical Director, the PCPs might not know how to perform a knee examination. Additionally, the Medical Director noted that the individual could have a McMurray's sign or joint-line tenderness. However, it should be noted that a McMurray's sign is indicative of meniscal damage and not osteoarthritis of the knee. On 9/20/20, the AMA was performed. On 8/25/20, the orthopedist documented that the individual's left knee examination was pertinent for the presence of an effusion and joint-line tenderness.

- In Individual #412's AMA, the assessment and plan section included a discussion of cardiac-related diagnoses as a group. A clear assessment (i.e., current status) and plan, as State Office policy requires, was not documented.

  For the diagnosis of hypertension, the PCP documented that over the last year approximately 11 blood pressures readings were above parameters and the individual was asymptomatic. The next year's supports were primarily assigned to nursing.

  There was no clear assessment of the medical condition, nor was there a clear medical plan of care. The target blood pressure for this 41-year-old female was 140/90. The assessment did not include relevant data, such as the presence or absence of target organ damage.
- According to the AMA, Individual #137 was diagnosed with CKD. The PCP documented that the cardiologist was managing the CKD. During interview, the PCP acknowledged that the assessment and plan of care were incomplete. The assessment did not include the stage of disease, the cause of the CKD, or the presence of urinary protein. Proper staging is needed to determine the medical plan of care, the intensity of treatment, and the type and frequency of monitoring. Additionally, the PCP did not note if the individual met any criteria for referral to a nephrologist.
- Individual #137 was diagnosed with osteopenia that was treated with calcium and Vitamin D3. On 9/6/18, the most recent DEXA scan showed osteopenia.

  In the AMA, the assessment and plan did not document a FRAX score or assessment of the need for additional medical therapy. Per the AMA, "DEXA has been ordered." The risk assessment of the AMA included a FRAX score, but incorrectly stated there was no diagnosis of osteopenia or osteoporosis.

The PCP stated during interview that the day prior to the interview, a DEXA scan was ordered.

- According to the AMA, completed on 3/7/21, Individual #203 was diagnosed with a seizure disorder related to long standing encephalomalacia of the left brain. The AMA further stated that the neurologist recommended continuing medications, which included clobazam, clonazepam, and Topamax. Per PCP documentation: "Her seizures have not really ever been under complete control." The plan included avoidance of stressful situations, providing medications, and attending neurology appointments. The goals were to have no more than one seizure per month, achieve medication compliance, and attend neurology appointments. The PCP did not indicate that medication compliance or attending appointments were problematic. There was no discussion of laboratory and other monitoring required for use of the medication regimen or the frequency of neurology evaluation.

  The neurology consult, dated 3/5/21, documented that the medication regimen consisted of clonazepam, Onfi, Vimpat, and topiramate. The diagnosis was refractory epilepsy with "reported full seizure control on a multi-drug regimen." The assessments by the PCP and neurologist were dated two days apart, but were not congruent.
- The active problem list of Individual #203's AMA listed sarcoidosis as an active problem. Per the AMA assessment, the individual "refused 4/17/20 Chest x-ray to evaluate for possible Sarcoidosis." The plan was for the individual to have a pulmonary consult in the upcoming year to evaluate for possible sarcoidosis.

  The PCP provided no information regarding why the sarcoidosis diagnosis was being pursued. There was no documentation of medical history, physical examination, previous chest x-ray, laboratory findings, or an eye examination. There was no information included in the AMA to support the active diagnosis of sarcoidosis.
- In Individual #410's QDRR, dated 4/6/21, the Pharmacist made a recommendation to evaluate the benefit of completing a DEXA scan due to the individual's AED drug regimen. The PCP agreed with the recommendation.

  During interview, the PCP reported that in July 2021, a DEXA was ordered. This was three months after the PCP accepted the QDRR recommendation. According to the Center's lab matrix, individuals treated with AEDs should have a baseline DEXA within one year of starting an AED. At the time of the Monitoring Team's review in September 2021, the DEXA scan had not been completed.

  With regard to the risk of loss of bone mineral density (BMD) related to AED use, the individual was prescribed Vitamin D3 with the indication of supplementation. The AMA documented an active diagnosis of Vitamin D deficiency. During interview, the PCP was not aware of the current State Office guidelines related to target levels for Vitamin D. Per the QDRR, dated 7/28/21, the individual had a Vitamin D level of 72, and a recommendation was made to re-evaluate the dose. The PCP reported that the dose was decreased the next day and the plan was to recheck.
- According to the AMA, Individual #410 experienced both partial complex and pseudo seizures that were treated with phenytoin, diazepam, and clobazam. According to the assessment/plan, the partial complex seizures were controlled with the prescribed AED regimen. However, the PCP did not state the seizure frequency. Based on data in the records and the IMR done on 5/30/21, the individual was not seizure free. According to the IMR, the individual's last seizure was on 2/3/21.

The PCP noted that the individual also had a vagus nerve stimulator (VNS), which reportedly was adjusted multiple times. However, the most recent IMR documented that there was no VNS. The plan was to continue the "same supports," which included neurology follow-up every six months and annual monitoring of the Dilantin level. The goal was to control seizures "completely and permanently."

- For Individual #247, the PCP listed tobacco dependence as an active problem. The smoking history documented that the individual smoked one pack per day and was not interested in smoking cessation. The PCP did not document what type of smoking cessation was offered. The assessment and plan for the diagnosis of tobacco use disorder was blank.
- According to the AMA, Individual #429 was diagnosed with asthma and was followed by a pulmonologist. Per PCP documentation, the pulmonologist started the individual on treatment for gastrointestinal reflux disease (GERD) during her last visit, and she was scheduled for follow-up in August 2021. Based on PCP documentation, medication adherence appeared problematic.

  The PCP did not document the status of the asthma control, based on frequency and severity of symptoms, number of exacerbations requiring oral glucocorticoids, or the current level of lung function (if able to perform). Based on the AMA assessment information, it could not be determined if the individual had intermittent or persistent asthma. The plan was to continue using Symbicort and PRN inhalers and to encourage the individual to "allow proper assessments for a more informed treatment plan."
- Individual #429's AMA, completed on 3/23/21, included obesity as an active problem with the individual's weight documented as 140 pounds. Even though the individual met criteria for the diagnosis of obesity, she was provided a weight maintenance diet. The plan was to notify the dietician of weight changes, and encourage the individual to walk three times a week with the goal of losing one to two pounds per month.

  According to the IMR, dated 6/28/21, the individual experienced a 9% weight gain in one quarter. The documented weight was 69.49 kg (i.e.,153.2 pounds). According to the PCP and Medical Director's comments during interview, the individual was started on metformin to promote weight loss. However, the Medical Director indicated that overall, the use of metformin for weight loss had not been successful for most individuals. According to the PCP, lifestyle modifications were implemented. The PCP was not able to provide documentation related to modifications, specifically a plan to increase physical activity. After review of the records, the PCP acknowledged that there was no specific plan or program to address increasing the individual's physical activity.
- According to the AMA, Individual #319 smoked one cigarette every hour. However, tobacco use disorder was not listed as an active medical problem. Therefore, there was no plan to address this problem.

  During interview, the Monitoring Team asked the PCP what type of smoking cessation program was offered to the individual and what role Behavioral Health Services played in the assessment and treatment of her tobacco use disorder. The PCP did not offer any additional information related to this issue.
- According to the AMA, Individual #319 was diagnosed with constipation related to the use of anticholinergic medications. The individual was prescribed daily Citrucel for bowel management. It was documented that the individual did not require any PRN interventions for constipation. The plan was to encourage the individual to use Citrucel daily. There was no other discussion of non-pharmacologic interventions to address constipation.

- Individual #343 was diagnosed with nicotine dependence. The social smoking history did not provide any information on the pack year history. The assessment of the AMA noted that the individual "has a long history of smoking a pack a day of cigarettes." Per the AMA, in October 2020, the individual started using nicotine patches. During interview, the PCP stated that the use of the patch started on 6/26/21. The AMA did not address the State Office preventive care guidelines to perform lung cancer screenings. The individual met the age criteria, and the PCP documented a long history of smoking one pack per day. Based on this information, lung cancer screening should have been performed. The current PCP did not have any additional information related to lung cancer screening, and stated that she would need to conduct further research on this issue.

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. For 15 of the chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

#	Indicator	Overall Score	Individuals: 189	412	137	203	410	247	429	319	343
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	0% 0/2	0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of the 18 IHCPs reviewed included a full set of action steps to address individuals' medical needs. For 15 of the chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. For Individual #189:

- The PCP ordered an annual lab to check the individual's A1c, which was not consistent with generally accepted standards of care for an individual with diet-managed T2DM.
- His cardiac IHCP included an intervention to "ensure cardiology follow-up." The lack of measurability of this intervention made it unclear whether or not the PCP completed it.

Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
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. Due to problems with the production of documents related to Pharmacy's review of new orders, the parties have agreed that the Monitoring Team will not rate these indicators.											

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: Given the timely completion of QDRRs during this review and the past two reviews (Round 15 – 94%, Round 16 – 100%, and Round 17 - 100%), and consistent timely psychiatry reviews of the QDRRs (Round 15 – 100%, Round 16 – 87%, and Round 17 - 100%) Indicators a and c.ii will be placed in the category requiring less oversight. The quality of the QDRRs reviewed was high, with continued improvement noted over the past few reviews.			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	94% 16/17	2/2	2/2	2/2	1/2	2/2	2/2	2/2	2/2	1/1
	ii. Benzodiazepine use;	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1

	iii. Medication polypharmacy;	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1
	iv. New generation antipsychotic use; and	100% 13/13	N/A	2/2	2/2	2/2	2/2	2/2	2/2	N/A	1/1
	v. Anticholinergic burden.	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1
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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	88% 14/16	0/2	2/2	2/2	2/2	2/2	1/1	1/1	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.	Not rated (N/R)									

Comments: b. Overall, the QDRRs for individuals in the review group included the necessary content. For Individual #343, the QDRR, dated 5/19/21, was incomplete (i.e., the document provided only included recommendations), and so, the Monitoring Team did not rate it for quality.

For Individual #203, the QDRR, dated 4/6/21, included no recommendation for an annual eye exam for topiramate use. Her last exam occurred on 11/30/18.

c. For the individuals reviewed, it was good to see that psychiatrists reviewed QDRRs timely, and documented agreement or provided a clinical justification for lack of agreement with Pharmacy's recommendations.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was often presented to show they implemented them. The exceptions were for Individual #189 for whom both the QDRRs, dated 4/7/21, and 7/13/21, recommended that the PCP obtain a urine microalbumin/creatine lab. In April, the PCP agreed, but based on documentation submitted, the lab was not completed. The Pharmacist made the recommendation again in July, but based on review of the labs submitted in response to the document request, the lab was still not completed.

e. As noted with regard to Outcome #1, due to problems with the production of documents related to Pharmacy's review of new orders, the parties have agreed that the Monitoring Team will not rate this indicator.

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: N/A	Individuals:
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.	

Outcome 4 – Individuals maintain optimal oral hygiene.
This outcome is no longer rated.

Outcome 5 – Individuals receive necessary dental treatment.

Summary: Often, individuals reviewed did not receive necessary dental treatment on a timely basis. The remaining indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
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.	29% 2/7	0/1	1/1	0/1	N/A	1/1	0/1	0/1	0/1	N/A
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	43% 3/7	0/1	1/1	0/1	N/A	1/1	1/1	0/1	0/1	N/A
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.	0% 0/7	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	0% 0/4	0/1	N/A	0/1	N/A	0/1	N/A	0/1	N/A	N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	25% 1/4	N/A	N/A	0/1	N/A	0/1	1/1	0/1	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									

Comments: Individual #203 and Individual #343 were edentulous.

a. through e. As described above with regard to Outcome 3, there was no dentist available to provide needed dental treatment and the Center did not otherwise have arrangements in place to provide general dentistry services. In addition, as the Dental Director reported during the January 2021 review, no total intravenous anesthesia (TIVA) clinics were conducted since April 2020. For this review, staff

reported that since the January 2021 review, only one TIVA clinic was conducted (i.e., on 6/28/21). As a result, staff reported that 10 individuals were awaiting TIVA in order to have a general evaluation. An additional 28 to 30 individuals were pending treatment with TIVA for specific procedures and treatment that were outlined in their treatment plans. Clearly, the lack of dental resources at the Center impacted the provision of care, as described further below.

- Clinic staff reported that they worked with the IDTs and home staff to improve individuals' oral hygiene ratings. Moreover, there was a plan to expand the incentive program that rewarded individuals for compliance with appointments and oral hygiene regimens. This was positive. However, for this review, five of the seven applicable individuals did not have prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.
- Based on documentation submitted, four of the seven applicable individuals did not receive required tooth brushing instruction twice-yearly from Dental Department staff. Per Center staff, the tooth brushing program was suspended when COVID-19 restrictions were implemented. Staff reported that the program would start again the week following the review. However, based on review of documentation Center staff submitted (i.e., a document entitled "Current San Angelo Tracking Activities on Hold," dated 09/2021) the Center re-instated on-campus dental services on 5/27/20. Center staff did not provide a reason for the delay in re-starting tooth brushing instruction.
- None of the applicable individuals had up-to-date x-rays.
- For the four applicable individuals, Dental Department staff did not provide at least two topical fluoride applications per year.
- With regard to restorative treatment:
    - On 9/22/20, Individual #137 had decay noted. She needed hospital dentistry, which as described above was not available.
    - In August 2020, Individual #410 was diagnosed with multiple caries. At the time of the review, they remained untreated. Moreover, at the time of the 2019 annual dental exam, the dentist identified caries, but there was no evidence these had been restored.
    - On 8/14/20, the dentist documented that Individual #429 had caries, but no documentation was submitted to show restoration was completed.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: a. through c. Based on the documentation provided, during the six months prior to the review, none of the nine individuals in the physical health review group experienced a dental emergency.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.
The Monitoring Team no longer rates this outcome. The Center's responsibilities for suction tooth brushing plans and their implementation are now assessed as part of the Section F – ISP audit tool.

Outcome 9 – Individuals who need them have dentures.											
Summary: For individuals reviewed with missing teeth, the Dental Department did not always provide clinical justification for not recommending dentures. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	N/A
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. Individual #319 had four missing teeth, but the most current annual dental exam, dated 8/14/20, did not address a recommendation for 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 assessments at the onset of signs and symptoms of acute illnesses/occurrences that are in alignment with applicable guidelines, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It was positive that in most instances reviewed, nursing staff timely notified the practitioner/physician of individuals' signs and symptoms in accordance with the nursing guidelines for notification. If Center staff maintain their progress in this area, after the next review, Indicator b might move to the category requiring less oversight. For the six acute illnesses/occurrences reviewed, nursing staff developed acute care plans. All of them included some of the necessary interventions, but all six were missing key interventions. Nurses thoroughly implemented two of the six acute care plans. Currently, these indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	50% 3/6	1/1	1/1	0/1	1/1	0/1	N/R	N/R	0/1	N/R
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.	83% 5/6	1/1	1/1	0/1	1/1	1/1			1/1	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/4	N/A	0/1	0/1	0/1	1/1			0/1	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	100% 1/1	1/1	N/A	N/A	N/A	N/A			N/A	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1			0/1	
f.	The individual's acute care plan is implemented.	33% 2/6	0/1	0/1	1/1	0/1	1/1			0/1	

Comments: The Monitoring Team reviewed six acute illnesses and/or acute occurrences for six individuals, including Individual #189 – hospitalization for acute DVT of the left leg on 5/14/21, Individual #412 – infectious conjunctiva of left eye on 5/19/21, Individual #137 – herpes simplex virus (HSV) mucocutaneous on 7/15/21, Individual #203 – unstageable pressure injury to right great toe on 2/21/21, Individual #410 – acute paraphimosis on 6/18/21, and Individual #319 - paronychia of the left great toe nail bed on 3/18/21.

a. The acute illnesses/occurrences for which nurses performed initial nursing assessments (physical assessments) in accordance with applicable nursing guidelines were for Individual #189 – hospitalization for acute DVT of left leg on 5/14/21, Individual #412 – infectious conjunctiva of left eye on 5/19/21, and Individual #203 – unstageable pressure injury to right great toe on 2/21/21.

b. For most of the acute illness/occurrence reviewed, licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the SSLC nursing guidelines entitled: "When contacting the PCP." The only exception was for: Individual #137 – herpes simplex virus (HSV) mucocutaneous on 7/15/21.

a. through e. The following provide some examples of findings related to this outcome:

- It was positive that on 5/14/21, after staff reported that Individual #189's leg was swollen, nursing staff conducted the initial assessments in accordance with applicable nursing guidelines, and notified the PCP. In addition, on 5/21/21, upon the individual's return from the hospital, the nurse conducted assessments in accordance with the guidelines.

On 5/14/21, nursing staff initiated an acute care plan, and modified it upon the individual's return from the hospital. The plan included interventions in alignment with the applicable nursing guidelines. However, some of the interventions did not define the shifts on which nurses should conduct the specified assessments. The acute care plan did not include a specific goal that was clinically relevant, attainable, and realistic to measure the efficacy of interventions. Based on a sample of documentation, and as Center staff also identified, nursing staff did not consistently implement the interventions included in the plan.

- On 5/19/21, after Individual #412 complained that her eye was itchy, a nurse conducted an assessment in alignment with nursing guidelines, and then escorted the individual to the clinic. The PCP evaluated the individual and diagnosed infectious conjunctivitis.

  On 5/19/21, nursing staff developed an acute care plan that included many necessary interventions. However, some key interventions were not included. For example, the plan did not include an intervention for her prescribed ophthalmic eye drops to both eyes for seven days four times a day (QID). The plan included no interventions to prevent cross-contamination through the individual's bedding, such as changing her pillowcase. The plan also did not include preventive interventions in which the individual and/or staff could participate to prevent cross-contamination with her other eye, or re-infection. Based on a sample of documentation, nursing staff did not consistently implement the interventions included in the plan.
- In a personal injury report (PIR), dated 7/14/21, at 8:23 p.m., nursing staff documented that staff reported that Individual #137 had a cluster of fever blisters on the corner of her upper right lip. It was not until 7/15/21, at 7:57 a.m., that an RN documented an assessment. The PIR indicated that nursing staff applied "minor first aid," but did not define the first aid provided. It was not until 8:04 a.m., on 7/15/21, that nursing staff notified the PCP. Nursing staff should have notified the PCP at the time of the initial report, due to the infection risk posed to other individuals as well as staff, particularly pregnant staff. In addition, untreated fever blisters can be painful. On 9:36 a.m., on 7/15/21, the PCP ordered medication.

  On 7/15/21, nursing staff initiated an acute care plan that included most of the necessary intervention. It was good to see that nursing staff included interventions related to infection control that were in alignment with applicable standards. The intervention related to her pain medication was not consistent with the PCP's order. The acute care plan did not include a specific goal that was clinically relevant, attainable, and realistic to measure the efficacy of interventions. It also did not include clinical indicators that nurses would measure. Based on a sample of documentation, it was positive that nursing staff consistently implemented the interventions included in the plan.
- On 2/21/21, and 2/22/21, nursing staff followed relevant guidelines in initially assessing Individual #203's skin integrity issue on her right great toe, which was diagnosed as an unstageable pressure injury. Nursing staff notified medical staff, who ordered that the individual be seen in the out-patient wound care clinic.

  On 2/22/21, nursing staff initiated an acute care plan. It was not in alignment with the nursing guidelines for skin integrity. For example, it did not require nursing staff to provide measurements of the skin issue in order to allow determination of whether or not it was healing, worsening, or staying the same. The frequency of assessing the wound also was not specified. Interventions did not include specifics with regard to physician orders, such as removing the dressing, cleaning the wound, and re-dressing the wound. Based on a review of documentation, nurses did not consistently implement the interventions in the acute care plan and/or the PCP's orders. As discussed with the Chief Nurse Executive (CNE) and State Office Discipline Lead, during the remote review, missing documentation potentially showed treatment and/or medication variances/errors.

- In an IPN, dated 6/18/21, at 5:15 p.m., the nurse documented that: "RN notified by LVN at 1700 that [Individual #410] has swelling, redness, and buros [sic] to his penis. [The individual] states it hurts to urinate but was able to give a sample for dipstick." The nurse notified the nurse practitioner, who came to the home to assess the individual.

  On 6/18/21, nursing staff initiated an acute care plan. The plan included a number of necessary interventions, including instructions for direct support professionals (DSPs). However, it did not include instructions for how the individual could participate in his own care. He communicates verbally, and initially reported his own symptoms. The intervention related to pain assessments did not include an assessment for the 10 a.m. to 6 p.m. shift, even though he had medication ordered every six hours. The plan also did not define shifts for the twice-a-day (BID) cold compresses that the PCP ordered. Based on a sample of documentation, it was positive that nursing staff consistently implemented the interventions included in the plan.
- In conducting the initial nursing assessment of Individual #319's toe, on 3/18/21, at 11:41 p.m., the nurse did not assess her vital signs. The nurse documented that the individual's toenail was loose all the way back to the cuticle. The nurse placed the individual on the clinic list.

  On 3/18/21, nursing staff initiated an acute care plan. The plan included many of the necessary interventions. However, it only included pain assessments for one shift per day, and three of the interventions did not state on which shift nurses should complete assessments. Based on a sample of documentation, nursing staff did not consistently implement the interventions included in the plan.

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.

The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

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 that were sufficient 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, often IDTs 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: 189	412	137	203	410	247	429	319	343
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.	8% 1/12	0/2	0/2	1/2	0/2	0/2	N/R	N/R	0/2	N/R

b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/9	0/1	0/2	0/1	0/1	0/2			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).	25% 3/12	1/2	0/2	2/2	0/2	0/2			0/2	

Comments: As noted above, the Monitoring Team reviewed a total of 12 specific risk areas for six 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 nurses implemented them. 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 nurses implemented the interventions thoroughly. The exceptions were for: Individual #189's - aspiration; and Individual #137 – respiratory compromise, and diabetes.

One problem was the lack of measurability of the supports. For example, some of the individuals' IHCPs called for nursing physical assessments, but the IHCPs did not define the frequency (e.g., every shift, each Friday, on the first day of the month, etc.). As a result, it was difficult, if not impossible, to identify in IView entries and IPNs whether or not and where nurses had documented the findings from the interventions/assessments included in the IHCPs reviewed.

In some instances, nurses/staff did not consistently document the completion of assessments or other interventions included in IHCPs. At times, this placed individuals at significant risk. For example:

- Individual #189's IHCP for circulatory included an intervention for nursing staff to complete an assessment monthly of his extremities for signs and symptoms of DVTs. Based on a review of documentation for June through August 2021, nursing staff did not complete and/or document the required assessments. From 5/15/21 to 5/20/21, he was hospitalized for a DVT, and from 7/13/21 to 7/15/21, he was hospitalized for diagnoses of dehydration, and acute combined systolic and diastolic heart failure.
- Individual #203's skin integrity IHCP included an intervention for nursing, residential, and habilitation therapy staff to follow the PNMP for positioning and supports to prevent pressure areas from developing. Based on documentation submitted, no supporting data was found to show implementation, such as flow sheet that staff were following the PNMP to prevent pressure areas from developing. On 2/21/21, she was diagnosed with an unstageable pressure injury to her right great toe. On 4/27/21, she was diagnosed with an unstageable pressure injury to her right great toe.

b. As illustrated below, a continuing 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, and modifications to plans to address their needs. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- On 1/20/21, when Individual #189's IDT held his ISP meeting, they rated him at high risk for cardiac issues, but they did not develop an IHCP that met his needs. For example, an intervention for the RNCM to review blood pressures monthly for effectiveness of antihypertensives did not include parameters for reporting high or low readings to the PCP, and did not include

a frequency sufficient to meet his needs. They also included an intervention for nursing staff to complete monthly assessments of the individual's extremities for signs and symptoms of DVT. This intervention also did not identify a frequency consistent with his needs and was not written in measurable terminology to ensure that nurses identified changes, such as taking measurements to assess the individual for increased swelling, and assessing popliteal and pedal pulses of his lower extremities. As discussed above, nursing staff did not implement this intervention.

Following his ISP meeting, the individual experienced a number of hypertensive events requiring the administration of PRN medication [e.g., on 2/7/21 – blood pressure of 170/105 (new medication added on this date), 2/8/21 – 190/106, 2/15/21 at 9:01 a.m. – 177/120, 2/15/21 at 10:30 – 182/112, 2/15/21 at 1:53 p.m. – 169/92, 5/21/21 – 175/110, 7/13/21 – 190/112, 7/15/21 - 201/131, 8/12/21 – 190/98, and 8/13/21 - 180/102]. On 5/15/21, he was hospitalized for a DVT. From 7/13/21 to 7/15/21, he was hospitalized for diastolic/systolic heart failure. However, his IDT did not modify the interventions in his plan to meet his needs. For example, in February 2021, the IDT did not meet after the new blood pressure medication was added. Based on the records submitted, the IDT did not hold an ISPA meeting for his hospitalization on 5/15/21 for a DVT. For his hospitalization in July 2021, the IDT held an ISPA meeting, on 7/20/21. According to the ISPA, the IDT determined he was already at high risk for cardiac. The IDT merely stated "continue cardiac supports." The IDT did not document a review of the acute care plan, or a review of the effectiveness of the IHCP interventions. They did not revise the supports in the IHCP. As stated above, his IHCP was insufficient to address his cardiac risk in relation to hypertension and blood clots.

- Individual #412's IHCP for fractures included no preventative interventions. It included interventions to monitor her Vitamin D level and treat it, if necessary, and "encourage physical activity," which was not measurable. Otherwise, the interventions were reactive (i.e., reporting injuries).

  On 2/2/21, during a peer-to-peer altercation, she sustained a fracture to her nose with a mild head injury. On 2/3/21, the IDT met to discuss the incident, but only recommended that the individual let staff handle peer behaviors.

  On 4/29/21, she fell while wearing high heels, and on 5/7/21, she was diagnosed with a fracture to her right ankle. The only ISPA meeting the IDT held related to this serious injury was to discuss the rights restriction of one-to-one staffing to assist with the healing process. She also fell on 5/1/21, 6/1/21, 6/7/21, and 6/13/21. Based on the ISPAs submitted, the IDT did not revise her IHCP to meet her needs, and reduce her risk of fractures due to falls to the extent possible.
- Individual #412's IDT rated her at medium risk for constipation/bowel obstruction. She was prescribed six medications that contributed to a high anticholinergic burden. Between 4/26/21, and 7/21/21, she required PRN medications 12 times to address constipation. As noted above, on 4/29/21, she fell, and on 5/7/21, she was diagnosed with an ankle fracture. This changed her mobility status to non-weight-bearing, requiring the use of a wheelchair for periods of time. No evidence was found to show that the IDT met to discuss the impact of this change on her risk for constipation/bowel obstruction, or to discuss the 12 instances of constipation requiring medications to resolve. Her IHCP included no preventative interventions (e.g., fluid intake, fiber intake, exercise, etc.), and the IDT did not review it or revise it to address her increased risk.
- Individual #137 was at high risk for respiratory compromise. From 5/6/21 to 5/11/21, she was hospitalized for aspiration pneumonia. On 5/18/21, the IDT held an ISPA meeting to discuss the hospitalization, as well as an allegation of neglect. The individual was supposed to be elevated while lying in bed due to her dysphasia. The allegation was that on 5/3/21, she vomited in her bed and aspirated while lying flat.

Based on the Monitoring Team's review of her IHCP, dated 5/6/21, the interventions were not consistent with nursing guidelines for ongoing assessments of an individual at high risk for respiratory compromise who required multiple uses of supplemental oxygen. The IHCP also did not include preventive interventions, such as her positioning requirements. During the post-hospitalization ISPA meeting, the IDT discussed a special consideration to have one-hour checks while she was in bed and to train staff to take the blanket off her head to check for signs of vomiting. Nursing staff were also to implement respiratory distress/aspiration nursing guidelines for aspiration pneumonia. However, the IDT did not add these interventions to the IHCP. Her concerns related to respiratory compromise continued. For example, on 7/7/ 21, at 8:54 a.m., she required supplemental oxygen when she became unresponsive.

- At her ISP meeting on 3/23/21, Individual #203's IDT rated her at high risk for skin integrity issues. She had experienced a number of skin integrity issues during the previous year, including a Stage 3 pressure injury to her great right toe, on 2/21/21. However, the IHCP that the IDT developed did not include nursing interventions for ongoing assessments, other than the quarterly skin assessment that is required as part of the standard quarterly nursing physical assessments that all individuals receive. Despite the additional diagnosis on 4/27/21, of an unstageable pressure injury to her right great toe, the IDT did not review and/or revise the IHCP to meet her needs.
- On 9/1/20, Individual #410's IDT developed an IHCP to address his medium risk for cardiac disease. It included two nursing interventions; one was for nurses to take and record daily blood pressure readings, and the other related to labs according to the lab matrix and PCP orders. The intervention related to daily blood pressure assessments did not define the parameters that nurses should use for reporting to the PCP. The IHCP included no preventative interventions (e.g., related to diet, exercise, etc.).

  According to quarterly nursing assessments, he had multiple blood pressure readings outside of acceptable parameters. More specifically, the quarterly review, dated 3/5/21, indicated he had 30 blood pressure reading outside of the parameters, and the quarterly assessment, dated 7/12/21, documented he had 39 blood pressure reading outside of the parameters. Based on documents submitted, his IDT did not meet to discuss these ongoing concerns with his blood pressure, or to review the IHCP and add interventions (e.g., preventative interventions) sufficient to meet his needs and reduce his risk to the extent possible.
- Since his ISP meeting, on 9/1/20, Individual #410 experienced ongoing seizures (i.e., at least 11 seizures), including status epilepticus on 12/14/20, and the need for the use of PRN Diastat on 6/10/21. His IDT did not reflect his seizure management plan in the IHCP developed as part of the ISP, and despite ongoing seizures, the IDT did not meet to review and/or revise the IHCP.
- Between February 2021 and June 2021, Individual #319 fell at least 16 times. Based on documentation submitted, the IDT did not meet in March or June 2021 to discuss her falls, even though her IHCP included an intervention for the IDT to meet if she had three falls within 30 days, and she met this criterion.
- In an IPN, dated 4/16/21, at 1:52 p.m., a nurse indicated that Individual #319 said: "…my feet hurt." The nurse documented an assessment that included removing the individual's shoes and socks. The nurse noted 2+ pitting edema, macerated heels, redness and warmth to the touch of the individual's toes, and "very filthy feet." The nurse subsequently referred the individual to the clinic, requesting an appointment due to blisters on both feet. In a corresponding medical IPN, dated 4/16/21, at 4:25 p.m., a provider documented an assessment of cellulitis and disrupted toenails. Based on the ISPAs submitted, the IDT did not meet to discuss this diagnosis and/or the finding about the individual's hygiene. The IDT did not act to determine the

	effectiveness of the current interventions and/or make necessary changes to the IHCP. For example, the IHCP included an intervention for the RNCM to instruct direct support professionals to prompt the individual to shower routinely, and perform good skin hygiene. Given the diagnosis of cellulitis and the finding of "very filthy feet," the IDT should have considered the need to change this intervention and/or add action steps. For example, the IDT should have considered the possible need for the involvement of behavioral health services staff to assist in identifying strategies to gain the individual's cooperation with hygiene tasks.

Outcome 7 – Individuals receive medications prescribed in a safe manner.											
Summary: For the two applicable individuals, it was positive to see the inclusion in IHCPs or acute care plans of respiratory assessments for individuals with high risk for aspiration/respiratory compromise that were consistent with the individuals' level of need. However, nurses often did not implement them. At this time, Indicators d.i and d.ii will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).										
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.										
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.	0% 0/2	N/A	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia	0% 0/2	N/A	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A

	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.										
	a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).										
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.										
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).										
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.										
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 nine individuals, including Individual #189, Individual #412, Individual #137, Individual #203, Individual #410, Individual #247, Individual #429, Individual #319, and Individual #343.

d. For the individuals reviewed, the Monitoring Team identified concerns related to necessary respiratory assessments. The following describe the Monitoring Team's findings:

- On 5/6/21, Individual #137 was diagnosed with aspiration pneumonia. The related acute care plan included an intervention for nursing staff to complete lung sound assessments on two shifts each day (i.e., 6 a.m. to 2 p.m., and 2 p.m. to 10 p.m.). Based on a review of a sample of documentation from 5/13/21 to 5/16/31, nurses did not complete the required assessments on a number of shifts.
- Individual #203 was at high risk for aspiration/respiratory compromise and received enteral nutrition and medications. Her IHCP included an intervention for nurses to complete lung sound assessments before and after feedings. Based on a review of a sample of documentation from 5/29/21 to 6/2/21, nurses most often conducted lung sound assessments before enteral feeding and medications, but not after.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.

The Monitoring Team no longer rates most of the indicators related to this outcome. The Center's responsibilities for PNM-related personal goals/objectives are now assessed as part of the Section F – ISP audit tool. Information about the Center's compliance related to the referral of individuals to the PNMT is provided below

Summary: In four of the six applicable instances, the IDTs of the individuals in the review group made referrals to the PNMT, and/or the PNMT made a self-referral.		Individuals									
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
b.	Individuals are referred to the PNMT as appropriate:										

	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	67% 4/6	N/A	1/2	1/1	0/1	N/A	1/1	N/A	1/1	N/A

Comments: b.i. The Monitoring Team reviewed six areas of need for five individuals that met criteria for PNMT involvement. These areas of need included those for: Individual #412 – fractures, and weight; Individual #137 – aspiration; Individual #203 – aspiration; Individual #247 – choking; and Individual #319 - falls.

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

- As early as March 2021, Individual #412 should have been referred to the PNMT, but no evidence was found of a referral or review. More specifically, on 11/5/20, she weighed 172.6 pounds. Four months later, on 3/2/21, she weighed 193.6 pounds (i.e., a 12% gain). She continued to gain weight, and weighed 200.4 pounds in April, 205.6 pounds in May, and 233.2 pounds on 8/4/21. Since November 2020, this represented a gain of 60.6 pounds. On 7/21/21, the PNMT held a change-in-weight discussion, following which they requested that staff reweigh her to confirm her weight. Based on documentation submitted, the IDT did not provide or the PNMT did not discuss results of reweighing her. The PNMT noted that staff denied any increase in her by-mouth (PO) intake. During the PNMT meeting, on 9/15/21, they identified that she had gained 57 pounds during the last year. They decided to do an evaluation for her at that time.
- From 10/2/20 to 10/6/20, Individual #203 was hospitalized for aspiration pneumonia. The PNMT did not appear to review the RN post-hospitalization review. More specifically, on 10/7/20, the RN conducted observations of the individual's enteral feeding. The RN recommended: 1) PT involvement, because the individual's wheelchair was reclined too far; and 2) an OT assessment for a sensory item to decrease the individual's finger-sucking. On 10/8/20, the PNMT RN made four recommendations, including the two previously made, as well as: 3) an evaluation to rule out gum pain or other mouth issues; and 4) a bed positioning assessment. On 10/8/20, a PNMT note reflected a post-hospitalization review, but only the nurse signed the note. There was no evidence that any other PNMT member participated. She mentioned "more than 2 triggers of aspiration or GERD for consecutive months" should result in referral to PNMT." She also recommended that the Home Manager retrain staff related to HOBE positioning to prevent aspiration and GERD within two weeks. No further follow-up or review was recommended other than a review by the Pneumonia Committee. There was no evidence of further follow up by the PNMT and no rationale for not assessing or reviewing her as a team.

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.		Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343

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% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1	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.	11% 1/9	0/1	0/2	1/2	0/1	0/1	0/1	N/A	0/1	N/A
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% 0/3	N/A	0/1	0/1	N/A	N/A	N/A	N/A	0/1	N/A

Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews generally provided no specific information or data about the status of the implementation of the action steps. One of the problems that contributed to the inability to determine whether or not staff implemented supports was the lack of measurability of many of the action steps.

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

- For Individual #189, nursing staff reported falls on 5/27/21 (i.e., rolled out of bed onto the floor mat), and on 6/29/21, when he slipped on urine during a transfer. From the nursing documentation, it was not clear whether he urinated during the transfer, or staff had not wiped up the urine before they attempted to transfer him. These falls did not show up in the fall data the Center submitted or in the QIDP monthly summary. There was no evidence that the OT/PT completed follow-up for either fall.
- As noted above, as early as March 2021, the IDT should have referred Individual #412 to the PNMT for weight gain, but no evidence was found of a referral or review. More specifically, on 11/5/20, she weighed 172.6 pounds. Four months later, on 3/2/21, she weighed 193.6 pounds (i.e., a 12% gain). She continued to gain weight, and weighed 200.4 pounds in April, 205.6 pounds in May, and 233.2 pounds on 8/4/21. Since November 2020, this represented a gain of 60.6 pounds.

  Despite numerous ISPAs held, the IDT did not address her weight gain. The psychiatric medication reviews documented as ISPAs did not mention weight gain either. Her IHCP for weight only included interventions that her weight would be monitored, she would be weighed monthly with encouragement to eat healthy foods, and have increased activity.
- For Individual #412, on 5/5/21, and 5/8/21, the IDT held ISPA meetings related to her ankle fracture. However, the IDT discussed no actual specific Habilitation Therapy supports. On 5/6/21, an x-ray confirmed a nondisplaced fracture to the tip of the right lateral malleolus. The RNCM completed in-service training on proper transfers and use of the wheelchair. Habilitation Therapy was not represented at that meeting. On 5/11/21, the PT saw her. A temporary PNMP was issued at that time related to non-weight bearing status, leg elevation with use of wheelchair, reminders to not bear weight on the right during independent transfers, staff supervision and use of a shower chair during dressing while sitting on the edge of the bed. Ice packs were to be applied as needed with reports of pain for no more than 20 minutes at a time. This was not reflected anywhere in an ISPA. On 6/3/21, an orthopedist prescribed a walking boot. She no longer required the wheelchair. On 6/3/21, the IDT held an ISPA meeting related to the orthopedist appointment at which the PT was in attendance. The IDT

stated that she was to use an ace wrap and walking boot with full weight bearing, and that the OT/PT had been contacted to pick up the wheelchair. The IDT did not discuss termination of the shower chair, walking boot, or discontinuation of the PNMP. The PNMP was stamped as discontinued, it was not clear on what date the IDT agreed to its discontinuation. An IPN in follow-up to her orthopedist appointment on 7/8/21, stated that the fracture was not healed, and that she was not compliant with wearing her boot, but that the orthopedist strongly encouraged that she continue doing so. The recommendation was for subsequent follow-up in one month with x-ray. The IPNs were requested through 8/12/21, at which time it did not appear the follow-up had yet occurred. There was no evidence that the IDT met to discuss her noncompliance with wearing the boot and ace wrap.

- On a positive note, per the ISPA, dated 5/18/21, Individual #137's IDT held a post-hospitalization meeting during which they agreed to increase her supervision to one-to-one unless in bed with one-hour checks in bed with a bed alarm, and 30-minute checks if out of bed from 8:00 p.m. to 6:00 a.m. This was due to change-of-status, and potential increased risk for falls due to weakness after her hospitalization for aspiration pneumonia. Again, on 7/28/21, they held another ISPA meeting related to possible COVID-19 exposure. The plan included one-to-one supervision while ambulating, one-hour checks while in bed with a bed alarm, and stand-by-assist at all times.

- As discussed above, on 5/3/21, during a bed check, staff discovered that Individual #137 had had a large emesis, and she was lying flat in bed, which was not consistent with head-of-bed elevation (HOBE) recommendations. A piece of gum was discovered in the emesis as well. On 5/6/21, staff reported that the individual had altered mental status, was staring with decreased communication, and she had soiled herself, which was unusual. When nursing staff assessed her, her oxygen (O2) saturation was 90 to 93%, and she had abnormal lung sounds. She was sent to the ED and admitted. On 5/11/21, the PNMT RN completed a post-hospitalization review. Due to the diagnosis of aspiration pneumonia, on 5/12/21, she was referred to the PNMT. On the same date, the PNMT initiated an assessment, but they did not complete it until 8/19/21.

  The PNMT identified the etiology of the aspiration pneumonia as related to the individual's position in bed. However, the IHCP referred only to her position during the meals. The PNMT made a recommendation to monitor the individual's bed positioning weekly for one month, but no evidence was found to show this occurred. They also recommended monitoring to ensure she received the correct portion size weekly for one month, but no evidence was found to show this occurred. The PNMT was to review all episodes of emesis, but no evidence was submitted to show this occurred. More specifically, the last PNMT meeting minutes documentation was dated 9/9/21, and it did not reflect any findings of monitoring.
- In the OT/PT assessment, the OT/PT did not address etiology of Individual #203's pressure injury to her toe. A hold was placed on use of the right shoe and the therapists indicated that the etiology was multifactorial, but they did not discuss the multiple factors. They concluded that it was "not conclusively noted to be due to failure of her orthopedic shoe." However on 2/23 the right shoe was shown to have increased wear and shoes were replaced. The unstageable wound was noted on 2/23/21. The items were present recently replaced and until otherwise medically confirmed as the cause, the shoes were assumed to be effective. However, they then said that she would be reviewed at the next orthotic clinic for a more protective shoe and sock. The ISPA, for the meeting held on 2/23/21, provided a much more comprehensive discussion of the factors that might have

contributed to the wound. However, the IDT did not appear to address these factors in the IHCP developed after that time and/or during her ISP meeting.

- According to Document #TX-SG-2109-II.P.1-20, between January 2021 and May 2021, Individual #410 fell 13 times. Based on documentation submitted, the IDT had not addressed the etiology/underlying cause of his falls, but rather provided some level of "protection" for when he fell. It was not clear that the ball cap (i.e., padded ball cap insert in his personal hats) actually would prevent a head or facial injury in the event of a fall.

- According to Individual #247's IRRF, dated 2/2/21, he was at low risk with regard to choking. On 4/19/21, he choked on cereal, and his IDT held an ISPA meeting. Video review showed him taking large bites. He reportedly had no previous history of choking. The SLP completed a consult, and found this to be an isolated incident. He was briefly downgraded to a chopped diet, and then returned to a regular diet. Again, on 6/19/21, his IDT met to discuss a second choking event. According to a PNMT meeting summary, dated 6/23/21, on 6/19/21, he choked on a chicken strip due to eating fast. The PNMT recommended a SAP for safe eating. According to the Habilitation Therapy Director, the PNMT's assessment was not yet complete as of week of the remote review. After the second choking event on 6/19/21, the PNMT weekly summary indicated that a MBSS was ordered, and then reordered on 7/14/21. No evidence was found of follow-up, and no related IPNs were submitted. At the time of the document submission, no evidence was found of an IHCP for choking.
- On 5/31/21, Individual #319et criteria for referral to the PNMT due to having more than three falls in 30 days (i.e., she fell five times in May). Overall, in the ISP year from 2019 to 2020, she fell 24 times, and 21 times from 2020 to 2021. On 6/1/21, she was referred to the PNMT. On 6/7/21, the PNMT initiated an assessment, which they completed on 7/14/21.

  With regard to IDT response to her falls, the OT/PT evaluation indicated that she had 12 falls, which was down from 17 during the previous year. She was not compliant with PT interventions. The IDT discontinued her PNMP due to non-compliance with custom inserts. Insufficient evidence was presented related to this or to what strategies they used to address her non-compliance. There were no ISPAs submitted that addressed her falls, although there was a note by the PT on 7/8/21, that stated he met with the IDT to discuss potential options regarding compliance with a planned orthotics clinic referral. The IDT confirmed that she had a trust fund order of $70/month to be designated for shoes and replacements, therefore orthopedic shoes would not be recommended. The IDT confirmed that they had an incentive plan for compliance with PT appointments, but the IDT did not believe that it needed to be modified to include or to have a separate plan for daily compliance with her shoes and orthotics. The IDT reported that "[Individual #319] does not respond to praise or short term benefits and any likely incentives that would work for other individuals, are not things that [she] would find value in." The IDT agreed to try to think of additonal ways to reward compliance. The last sentence stated "If there is no incentive protam in place to support daily use of the planned custom foot orthotics, they will amlmost certainly result in noncompliance and IDT agrees." With no incentive plan in place the PT was going to meet with the OT and orthotist to determine if orthotics were recommended.

c. For the individuals reviewed whom the PNMT discharged, two of the assessments were overdue, and, as a result, they were of little utility to the IDTs in developing comprehensive plans to address the individuals' PNM needs:

- For Individual #412, on 5/26/21, the PNMT initiated an assessment for a fracture, but they did not complete it until 8/11/21. At this point, the fracture was healed.

- For Individual #137, on 5/12/21, the PNMT initiated an assessment related to aspiration pneumonia, but they did not complete it until 8/19/21.
- For Individual #319, the PNMT completed a review for falls on 7/14/21. There were no ISPAs submitted to reflect that the PNMT met with the IDT related to her falls, or wearing her shoes and custom orthotics. The last note submitted by the PNMT, dated 7/29/21, stated that the IDT and PNMT were "to discuss and create if approved by the IDT for an incentive program." The note was not fully legible as a part of the page was not visible to the reader. Based on the note by the PT on 7/8/21, there was no clear plan to develop an incentive plan for daily wear of the orthotics. There did not appear to be any closure by the PNMT, and no formal discharge from service.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: It was positive that during 95% of the observations, individuals' PNMPs were implemented as written. This was good progress from the previous three reviews, when the scores ranged from 68% to 74%. This outcome will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	95% 37/39	
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.	N/R	

Comments: a. The Monitoring Team conducted 39 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during 13 out of 13 observations (100%). Staff followed individuals' dining plans during 22 out of 24 mealtime observations (92%). Staff completed transfers correctly during two out of two observations (100%).

The following provides more specifics about the observations:

- With regard to mealtime observations:
  - During all of the observations of dining plan implementation, it was good to see that texture/consistency was correct, staff followed the interventions on the dining plan, and staff and the individuals observed were positioned correctly at mealtime.
  - In one instance, an individual was supposed to have a divided plate, but staff served her meal in a styrofoam container.
  - One individual was coughing during the meal. At one point, staff held his hand down briefly to pause his eating. Staff stated that he was coughing with the liquids. The individual also was tipping the cup up to drink rather than sucking liquids up from the straw. Staff stated that he does this when there is not much liquid in the cup. He did drink from the straw at other times during the meal.
- The 13 individuals observed requiring positioning supports were positioned correctly.

- It was positive that for the two transfers observed, staff followed safe transfer procedures.

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	189	412	137	203	410	247	429	319	343
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A				N/A					
Comments: a. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, the applicable individuals reviewed who had needs for formal OT/PT services did not have clinically relevant or measurable goals/objectives to meet those needs. To move forward, it will be important for IDTs and OTs/PTs to work together to ensure recommendations for clinically relevant and measurable goals/objectives are considered, and that, as needed, goals/objectives are developed, and implemented. It will also be important for OTs/PTs to work with QIDPs to include data and analysis of data on those OT/PT goals/objectives in the QIDP integrated reviews. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/5	N/A	N/A	0/1	0/1	N/A	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/5			0/1	0/1		0/1		0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/5			0/1	0/1		0/1		0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/5			0/1	0/1		0/1		0/1	0/1

e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/5			0/1	0/1		0/1		0/1	0/1

Comments: a. through c. Individual #189, Individual #412, Individual #419, and Individual #429 did not have identified needs requiring a formal OT/PT goal/objective, but all required OT/PT supports and services [e.g., a Physical Nutritional Management Plan (PNMP]. The remaining five individuals did have needs requiring OT/PT supports and services, but none had clinically relevant or measurable goals/objectives to address those needs, or justification showing why supports were not necessary.

The Monitoring Team conducted full reviews for all nine individuals. Individual #189, Individual #412, Individual #419, and Individual #429 did not have identified needs requiring a formal OT/PT goal/objective, but all required OT/PT supports and services, so a full review was not completed for each of them.

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

Summary: To move forward, QIDPs and SLPs should work together to make sure individuals' OT/PT needs are addressed in their ISPs/ISPAs and that QIDP monthly reviews include data and analysis of data related to the implementation of OT/PT strategies and SAPs. These indicators will remain in active oversight. These indicators will continue in active oversight.

			Individuals:								
#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	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	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. Overall, as described above with regard to Outcome 1, applicable individuals did not have measurable strategies and action plans included in their ISPs/ISPAs related to OT/PT supports.

b. For Individual #412, Center staff did not provide evidence the IDT met to discuss and terminate all supports initiated as a result of the right ankle fracture that occurred on 4/29/21. She initially required the use of a wheelchair while non-weightbearing and, after her orthopedic appointment on 6/3/21, the IDT met on that date to discuss terminating the use of the wheelchair and implementing the use of a walking boot. At that time, the ISPA also documented a need for follow-up x-rays in one month's time to assess the status of healing. The Center did not provide evidence the IDT met again after that to discuss her non-compliance with wearing the walking boot or terminating any other related PNMP modifications.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Twenty-two out of 23 individuals observed had assistive/adaptive equipment that appeared to be the proper fit. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	203	25	98	369	315	202	150	328	383
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category of 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.	96% 22/23	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		137	268	248	31	273	214	447	116	140
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
		Individuals:									
#	Indicator		429	186	119	118	189				
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1				
c. Based on observations of 23 pieces of assistive/adaptive equipment, most appeared to be the proper fit for the individuals. The exception was for Individual #116 for whom the sling back of her wheelchair was broken down and did not provide adequate support.											

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, five indicators were already in, or were moved to, the category of requiring less oversight. At this review, no other indicators will be moved to this category.

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

There were few SAPs and little implementation.

All SAPs contained many of the required components, but every SAP was missing one or more of the required components. Some were not written in a way that would allow staff to implement the plan correctly and consistently

Not all SAPs were reviewed monthly and/or did not have accurate data.

The Center should continue to focus on ensuring individuals have their AAC devices with them. 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.

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: Few SAPs (14) and little implementation resulted in small denominators for these three indicators. All will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
6	The individual is progressing on his/her SAPs.	33% 1/3		1/1	0/1					0/1	
7	If the goal/objective was met, a new or updated goal/objective was introduced.	100% 1/1						1/1			
8	If the individual was not making progress, actions were taken.	50% 1/2			0/1					1/1	
9	(No longer scored)										

Comments:
6. Eight (e.g., Individual #189's counting decorations SAP) SAPs were judged to be unmeasurable (see indicator 2). Additionally, Individual #471's reading SAP, Individual #413's complete a job application SAP, and Individual #201's microwave SAP had insufficient data to determine if they were progressing. Individual #376's showering SAP was progressing. Individual #383's microwave SAP and Individual #471's counting coins SAP were not progressing.

7. In May 2021, Individual #201's showering SAP moved from step 2 to step 3 due to achieving the object.

8. Individual #471's July 2021 progress note indicated that her counting coins SAP would be terminated due to lack of progress. Individual #383, however, had refused to participate in her microwave SAP for seven months with no evidence of action to address the lack of progress.

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

Summary: All SAPs contained many of the required components, but every SAP was missing one or more of the required components. Some components were present, but as detailed in the comments below, were not written in a way that would allow staff to implement the plan correctly and consistently (or to meet criteria with this monitoring indicator). This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 413	376	383	300	450	201	412	471	189
13	The individual's SAPs are complete.	0% 0/14	0/1 5/9	0/1 8/10	0/1 6/10	0/2 14/20	0/2 9/18	0/3 22/30	0/1 6/9	0/2 15/19	0/1 6/10

Comments:
13. In order to be scored as complete, a skill acquisition plan (SAP) must contain 10 components necessary for optimal learning. None of the SAPs were 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 none of the SAPs were judged to be complete, many of the SAPs contained the majority of the components, and 100% of the SAPs had a plan that included:

- behavioral objectives
- relevant discriminative stimuli
- teaching schedule

Regarding common missing components:

- Many of the SAPs would benefit from more instructional detail. An improvement from previous reviews was that the majority of multi-step SAPs specified if non-training steps were to be reviewed in each training session. Some SAPs that instructed staff to review a previously mastered step, however, did not instruct staff of how to respond/record if the individual did not complete the previously trained step at the goal prompt level (e.g., Individual #376's showing SAP). Several other SAPs (e.g., Individual #300's put on her makeup SAP) indicated that staff should continue with the untrained steps, however, there was no detail as to how to continue with those steps. Instructions on how to present the untrained steps should be specific. For example, staff may be specifically instructed to allow an individual to be as independent as possible on the untrained steps, and use least-to-most prompting as necessary to complete the SAP. Individual #383's use the microwave SAP instructed staff to complete all the steps of the SAP and only record the training step, however, the SAP training sheet did not include any of the steps (i.e., task analysis), therefore, making it impossible for staff to consistently train this skill.
- Other SAPs (e.g., Individual #413's complete her work application SAP, Individual #450's write in cursive SAP), indicated that verbal prompts were to be used if the individual could not independently complete the task. The verbal prompt provided in the training sheet, however, simply repeated the initial instruction (e.g., fill out the references section) rather than providing specific verbal prompts that lead to the correct response (e.g., stating this section should include your references, those are the people that will tell potential employers what type of person and worker you are).
- Several SAPs (e.g., Individual #412's reading SAP) included multiple verbal or gestural prompts as the objective. The staff instructions, however, did not specify how many verbal prompts could be used. The SAP data collection method did not allow staff to record the frequency of prompts, only the type. Therefore, when verbal prompts are recorded it is impossible to determine if it represents one or two prompts and, therefore, impossible to determine if it meets the objective. One way to address this issue would be to specifically instruct staff that verbal prompting is defined as one or two prompts only (see indicator 2 comments).
- Some SAPs included steps that were not operationally defined. For example, Individual #201's brush his teeth SAP instructed staff to brush all areas of his teeth. In order to ensure consistency in training among all staff, those areas and the length of time he brushes should be specified.
- 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 the majority of SAPs (e.g., correct responding in Individual #300's apply her makeup SAP specified that she should be given a token which could be exchanged for tangible reinforcers) and represents an improvement from the last review. A few SAPs, however, merely included staff saying "good job," which was not documented to be a preference for the individual (e.g., Individual #450's counting coins SAP) for the individual.
- Finally, all of the SAPs had complete generalization plans, however, some SAPs (e.g., Individual #471's reading SAP) did not have a complete maintenance plan that specified how San Angelo SSLC would ensure that the individual maintains the skill once it is mastered (e.g., require that the individual continue to independently complete the SAP).

Outcome 5- SAPs are implemented with integrity.												
Summary: Two of three SAPs were observed to be implemented as written. Four individuals refused to participate in the SAP implementation. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
14	SAPs are implemented as written.	67% 2/3	1/1	Unable	Unable	Refused	Refused	0/1	Unable	Refused	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
14. The Monitoring Team observed the implementation of Individual #413's fill out a job application, Individual #201's use the microwave, and Individual #186's use the microwave SAPs. Individual #186 was not one of the individual's reviewed, however, the opportunity to observe her SAP was available. Individual #186 and Individual #413's SAPs were judged to be scored and implemented it as written. The DSP implementing Individual #201's SAP, however, did not follow the prompt sequence specified in the SAP training sheet. Rather he moved back and forth among verbal, gestural, and physical prompts.

Attempts to observe additional SAPs were made. Individual #471, Individual #450, and Individual #300 refused to participate. Individual #189 started his SAP and then refused. Individual #412 started her reading SAP, but indicated that she could not see the words because of an eye infection, and Individual #383 indicated she could not set the timer on the microwave because of physical limitations. Individual #376 only had a showering SAP that was not observed due to privacy.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.												
Summary: Not all SAPs were reviewed monthly and/or did not have accurate data. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
16	There is evidence that SAPs are reviewed monthly.	29% 4/14	0/1	0/1	0/1	1/2	1/2	0/2	2/3	0/2	0/1
17	SAP outcomes are graphed.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
16. Several SAPs were either not included in the monthly reviews (e.g., Individual #300's put on her makeup SAP) or did not include accurate data (e.g., Individual #376's shower SAP).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.												
Summary: These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	25% 1/4			0/1	0/1			0/1		1/1

Comments:

18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the remote review week. The Monitoring Team found Individual #383 and Individual #376 to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. San Angelo SSLC began reimplementing engagement assessments in June 2021. Individual #189, Individual #412, Individual #300, and Individual #383's residences all had engagement assessments in June and July 2021. All four of these residences had goal engagement level scores, and Individual #189's residence achieved it's engagement goal level. The Monitoring Team was encouraged to learn that San Angelo SSLC was beginning to reimplement engagement monitoring in treatment sites.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Community outings, following all COVID precautions, were occurring during the review period. None of the individuals yet met their goals for outings, but given COVID precautions, this was not surprising. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	413	376	383	300	450	201	412	471	189
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.	N/A									
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.	N/A									

Comments: 22. San Angelo SSLC reestablished community outings since the last review. All individuals had six months of community outing data. Additionally, three outings a month was established as each individual's outing goal. None of the individuals achieved this outcome, however, it was good to learn that community outings were reinitiated. 23. No community SAP training data were available.

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.
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

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: For the one individual reviewed who needed formal communication services and supports to expand or explore communication options and skills, the IDT did not develop any clinically relevant and/or measurable goals/objectives. To move forward, it will be important for IDTs and SLPs to work together to ensure recommendations for clinically relevant and measurable goals/objectives are considered, and that, as needed, goals/objectives are developed, and implemented. It will also be important for SLPs to work with QIDPs to include data and analysis of data on those communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.	Individuals:

#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/1				0/1					
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/1				0/1					
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 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% 0/1				0/1					

Comments: a. through e. Individual #189, Individual #412, Individual #137, Individual #410, Individual #247, Individual #429, Individual #319, and Individual #343 all had functional communication skills and did not require formal communication goals/objectives. Only Individual #203 had communication needs that required clinically relevant and measurable goals/objectives to meet those needs, but she did not have any.

The Monitoring Team conducted full reviews for six individuals. As noted above Individual #189, Individual #412, Individual #137, Individual #410, Individual #247, Individual #429, Individual #319, and Individual #343 had functional communication skills and did not require formal communication goals/objectives. Individual #189 and Individual #412 were selected for a cross-team review, so the Monitoring Team completed full reviews for them. Individual #429, Individual #319, and Individual #343 were part of the core group, so full reviews were conducted for them. For Individual #203, the Monitoring Team completed a full review due to a lack of clinically relevant, achievable, and measurable goals to address her communication needs. Individual #137, Individual #410, and Individual #247 were part of the outcome group, and did not have any specific communication-related supports, so limited reviews were conducted for them.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.

Summary: To move forward, QIDPs and SLPs should work together to make sure individuals' communication needs are addressed in their ISPs/ISPAs, and that QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	189	412	137	203	410	247	429	319	343

a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	N/A			N/R		N/R	N/R			
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: Individual #137, Individual #410, and Individual #247 were part of the outcome group, and did not have any specific communication-related supports, so these indicators were not rated for them.

a. As described above, the applicable individual did not have needed measurable strategies and action plans included in her ISP/IHCP, so there was no basis for assessment of these indicators.

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. 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."]

#	Indicator	Overall Score	Individuals: 211	203	25	98	202	150	287	251	389
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	67% 10/15	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	50% 3/6	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
			Individuals:								
#	Indicator		253	50	154	308	270	194			
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		0/1	0/1	1/1	0/1	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.		0/1	0/1	N/A	N/A	1/1	1/1			

c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	N/R

Comments: a. and b. Based on observations for individuals reviewed, Individual #203, Individual #389, Individual #253, and Individual #50 did not have their home-based AAC devices/supports present and readily accessible. By report, Individual #308's was available to him when he went to the kitchen door. This was appropriate for eating and drinking, but not in context for the other two items (i.e., medications and hurt).

b. Due to the limitations inherent in the remote review, the Monitoring Team was often unable to observe individuals actively using their devices/supports in the prescribed settings. For example, for Individual #203 and Individual #308, the Monitoring Team member prompted Center staff to retrieve the devices/supports (i.e., a communication book and choice board, respectively) that were not readily available, but the context of the observation did not present an opportunity to engage in any functional use. In these instances, the Monitoring Team scored the observation as not applicable (N/A). The following provides a description of concerns noted:

- For Individual #389, Center staff reported that his devices/supports (i.e., fidget sensory objects) were often taken by other individuals and that they were missing at the time of the observation.
- Although Center staff were able to retrieve Individual #253's daily calendar for observation, it was not functional because it still included an activity (i.e., newspaper delivery) in which he did not participate at the time due to COVID-19 restrictions.
- At the Monitoring Team's request, Center staff also retrieved Individual #50's absent sign language reference cards from an office. Center staff indicated the cards were for new staff to consult if the individual used a sign they did not know. This support could be used in a functional manner in any context.

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, four indicators were moved to the category of requiring less oversight due to sustained high performance. At this time, no additional indicators will be moved to this category.

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

Despite ongoing COVID-19 challenges to the transition process, the Center had completed nine transitions since the previous review, with no individuals returning.

The APC's office continued to focus on the implementation of quality improvement initiatives to address discipline transition assessments and to improve pre-move training and provider competency testing, with a primary emphasis on training for nursing and behavioral health staff.

There were continuing practice improvements in other areas as well. For example, it was good to see the PMM made clear, concise and thorough comments for all post-move supports and, in most instances, correctly assessed whether supports were in place and identified when follow-up action was needed.

It was also very good to see that the Placement Coordinator regularly helped IDTs to identify unaddressed support needs and then develop the needed post-move supports.

As previously reported, the adequacy and measurability of pre-move provider staff training supports continued to be of concern for the two individuals reviewed. None of the supports specified the competency criteria by which provider competence could be measured and the competency testing still did not address many of the individuals' important needs. We again encouraged transition staff to make this a priority.

One individual had experienced a PDCT event related to behavioral and psychiatric issues. In reviewing the event, the IDT did have a thoughtful discussion, but still needed to dig a little deeper to identify things they could have done differently – and could do differently in the future. In this instance, the IDT agreed they did not train on the issue of elopement, because the individual did not have this history. However, a review of his history indicated he had at least one similar incident when living in the community in the past.

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: There were a number of improvements in the set of pre- and post-move supports since the last review. Even so, additional detail remained needed in the training of community provider staff and in the comprehensiveness of the list of supports. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 299	80							
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: Nine individuals transitioned from the Center to the community since the last review. Two were included in this review (Individual #299, Individual #80). Both individuals transitioned to a community home operated under the State's HCS program. The Monitoring Team reviewed these two transitions and discussed them in detail with the San Angelo SSLC Admissions and Placement Coordinator (APC) and other transition staff.

It was very positive and instructive that Center transition staff had reviewed one of the two CLDPs chosen by the Monitoring Team in depth prior to the meeting held during this remote review.

1. Overall, this indicator did not meet criterion, although improvement was noted with regard to measurability of post-move supports. 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 five pre-move supports for Individual #299 and 11 pre-move supports for Individual #80. Most pre-move supports (i.e., three for Individual #299 and six for Individual #80) were for pre-move provider staff training or clinician-to-clinician information sharing. None of the supports specified the competency criteria by which provider competence could be measured and the competency testing still did not address many of the individuals' important needs. This should be a priority for the transition staff. Center staff should focus on defining specific competency criteria and ensuring the tools for measuring those competencies are thorough and appropriate to the respective needs. Findings included:
  - For both individuals, the pre-move training supports for behavioral needs broadly described the topics that should be included (i.e., a behavioral history and overview of the PBSP for Individual #299 and a positive behavioral support plan (PBSP) that addressed verbal aggression for Individual #80), but did not provide any competency criteria. In other words, the supports did not describe the specific knowledge and/or skills that provider staff needed to have or to learn. As a result, it was not possible to reliably measure whether the training addressed their specific needs.
  - The nursing pre-move support for Individual #299 indicated the training would cover her psychiatric medications, diagnoses, custom foot orthoses (CFOs,) the Integrated Risk Rating For (IRRF) and related staff instructions, the

Integrated Health Care Plan (IHCP), and her diet. However, the pre-move training supports did not provide any specific expectations for staff knowledge in these areas. For Individual #80, the pre-move training support indicated it would cover training on the IHCP, including his health risk ratings and interventions. Beyond these broad categories, this pre-move support did not include any specific expectations for staff knowledge.

- In addition, for Individual #80, the OT/PT pre-move training support indicated broadly that training would address custom shoe inserts, orthopedic shoes and boots, and headboard blocks, but provided no criteria (i.e., expectations for the specific knowledge provider staff would need to know.)
- Although the pre-move training supports did not provide any standards or criteria against which competency could be measured, they typically included reference to the tools used to measure competency. Overall, Center staff relied upon written quizzes, requiring a score of 100%, for this purpose. However, as reported during previous reviews, none of the written exams tested 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. The written tests reviewed for these two CLDPs did not include questions for many of the topics and/or competencies covered in the training materials, or in the pertinent assessments, so there was no corresponding measurable evidence of related staff knowledge. Examples included, but were not limited to, the following:
    - For Individual #299, the health/nursing quiz cover sheet indicated the training covered direct support professional (DSP) instructions, the individual's diagnoses, medications, and allergies, the IRRF, and the IHCP. The quiz itself consisted of 10 questions, but these did not test competencies for all of the needs included in the training. Without clearly stated competency criteria, it was not possible to discern if these 10 questions adequately addressed what provider staff needed to know. For example, three true/false questions related to DSP instructions addressed if provider staff needed to encourage the individual to 1) drink milk and eat cheese (false due to history of lactose intolerance), 2) remain upright at least 30 minutes after eating (true) and 3) make healthy food choices (also true). However, the quiz did not include any questions that addressed the following instructions for provider staff, including required reporting to nursing:
        - Related to her cardiac risk: unsteady gait, drooling, unusual tics/movements to drowsiness.
        - Related to her skin integrity risk: any redness over a bony area, white moist skin, peeling or flaking skin, a break in in the skin, or any swelling.
        - Related to her risk for risk for infection: to encourage her to wipe front to back when voiding and to report any itching and or drainage from her perineal area.
    - Individual #299's PBSP quiz consisted of five questions, which did not address many significant behavioral strategies. For example, one question asked provider staff to select her current replacement behaviors from a list, including Gains Item, Meaningful Activities, and Delayed Gratification. However, the quiz did not probe provider staff knowledge about how to implement the specific instructions for any of the replacement behaviors. In addition, one of the important strategies in Individual #299's PBSP addressed specific requirements for observation checks related to stealing property of others. The quiz did not address these requirements.
    - For Individual #80, the nursing quiz included several questions referencing signs and symptoms (e.g., for migraine) and side effects but did not address provider staff knowledge, including the need to report to nursing, for any of the following elevated risk areas:

        - Related to risk factors for gastrointestinal issues: to notify the primary care physician (PCP) if no bowel movement for longer than 3 days; to encourage Individual #80 to drink 1.5 - 2 liters of water and to sit up at least 1 hour after meals; and to ensure his head of bed was raised with headboard blocks at all times.
        - Related to risk factors for infections and skin integrity: to be aware he was prone to tinea cruris or fungus in groin and to encourage Individual #80 him to shower at least daily and dry off thoroughly and to change clothes and underwear daily, and to notify nursing if Individual #80 has any raised areas, redness or skin irritation
        - Related to risk factors related to seizures: to make note of the type of seizure (limb jerking, eyes rolled back, etc.), and time the length of the seizure, and to notify the nurse or PCP.
    - The quiz for Individual #80's PBSP consisted of seven questions, most of which were in a true/false format. The questions did not address reinforcement, psychiatric indicators (e.g., self-neglect, emotional withdrawal, uncooperativeness, etc.), prevention strategies (e.g., not to ignore him, prompt him to use deep breathing techniques, etc.), or his functional replacement behavior of functional communication (i.e., approaching staff/peers and having a conversation about a topic, making eye contact when speaking, and completing his sentences/thoughts after stuttering begins to emerge.). The quiz also did not address behavior antecedents/setting events, which included being denied and/or running out of tobacco dip.
- Post-Move: The respective IDTs developed 42 post-move supports for Individual #299 and 41 post-move supports for Individual #80. The following describes examples of progress and areas for continued improvement:
    - Many post-move supports were measurable, which was positive. For example, at the time of the previous review, IDTs did not always develop post-move supports that defined measurable outcomes related to the achievement of individual's community employment goals. It was therefore good to see that these two CLDPs included supports with specific expectations for both the initiation of TWC assistance and an actual outcome of achieving employment.
    - In addition, IDTs also made some improvement with regard to providing specific monitoring parameters when needed. For example, Individual #299's CLDP included two good post-move supports for checking her blood sugar and blood pressure levels that told provider staff when to test the levels, how to know if the levels were outside acceptable parameters, and what steps to take if that occurred. However, some improvements were still needed. For example, Individual #299 also had a post-move support for quarterly visits with her mother and sisters, but did not include the supervision parameters described in the ISP (i.e., plans for unsupervised visits could be scheduled once supervised visits have gone well and the guardian has completed necessary background checks). For Individual #80, the CLDP included a support for head-of-bed elevation using blocks provided by the Center, but needed to specify the actual elevation required (e.g., in case the blocks were misplaced or needed to be replaced).
    - As reported for previous monitoring periods, for both individuals, other exceptions related to measurability were the post-move support for training of any new staff. These supports were structured in the same manner as the pre-move training supports described above that were not measurable.

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 further below. As reported previously, Center staff should place a strong focus on ensuring IDTs address all significant behavioral, medical, safety and healthcare needs with adequate supports.

- Past history, and recent and current behavioral and psychiatric problems: Although there was improvement observed since the previous review, Center staff still did not address a number of important behavioral support needs, and neither met criterion. To meet criterion, the IDTs should continue to make improvement toward developing comprehensive supports that address behavioral and psychiatric history and needs. Findings included:
    - As described above with regard to Indicator 1, neither IDT developed pre-move supports that ensured provider staff had sufficient knowledge to meet their behavioral needs.
    - For both individuals, the respective IDTs also did not develop specific and detailed post-move supports that described how provider staff should address all of their important and current behavioral needs. While it was positive that both CLDPs included specific and measurable post-move supports with regard to the many of the individuals' target behaviors and management techniques, neither included post-move supports for implementation of the prevention and reinforcement strategies or for their replacement behaviors. In addition, Individual #299's behavioral support required provider staff to implement observation checks related to her target behavior of stealing, but did not include any of the detailed steps for completing that process. Of note, as described above with regard to Outcome 1, the Center's behavioral competency also did not probe staff knowledge of these steps.
    - Neither CLDP included sufficient supports for staff knowledge of the individuals' significant behavioral histories:
        - Based on documentation provided for review, Individual #299 had a history significant for challenging behaviors when living in the community in the past, including physical aggression, verbal aggression, and property destruction. It was reported challenging behaviors were usually in response to not getting what she wanted and/or when she wanted it. She was also arrested several times due to assaulting her housemates and/or staff. The history also indicated she experienced suicidal ideation during that time, but reportedly did not act on it. However, on 5/21/21, her IDT met to discuss threats she made to cut herself, so provider staff needed to be aware.
        - For Individual #80, documentation indicated, in addition to his current target behaviors, he had a history pica, stealing, leaving supervision, refusals of medications, dental appointments, daily hygiene, and program attendance, as well as of inappropriate sexual behavior, including fondling children and inappropriately touching a female while living in a group home. While living in the group home, he had significant anxiety and an episode of suicidal gesture and ideation wherein he walked into traffic attempting to get struck. The CLDP did not include any supports to ensure that provider staff had knowledge of this history.

- 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. However, to meet criteria, the IDTs still needed to develop clear and comprehensive supports in each of 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. Neither CLDP met criterion. Findings included:
    - Neither CLDP included a post-move support that clearly outlined the individuals' supervision needs.
    - Both individuals received medications with risk of anticholinergic side effects. Based on the IRRF, these side effects could include dry mouth, which could interfere with swallowing; blurred vision & dizziness, which can cause

ambulation problems; constipation, which could develop into fecal impaction; urinary retention, which could increase the risk of infections or overflow incontinence; and can also cause confusion or decline in cognition. The CLDP did not include any supports for provider direct support staff knowledge of the individuals' high risks for medication side effects, or requirements to monitor for and report any signs/symptoms to nursing staff.

- Other than completion of side effects testing (i.e., the AIMS), neither CLDP included any specific requirements for periodic or routine nurse monitoring of their health risk areas.
- Both individuals had communication needs and strategies provider staff needed to know, but neither CLDP included communication-related post-move supports. Examples of needs not addressed included the following
    - Individual #299 used glasses and should wear them to see who she is communicating with well. Staff should speak directly to her and make eye contact and might need to prompt her to stay on topic and work with her on trying not to repeat herself.
    - For Individual #80, the ISP indicated that patience was sometimes required in conversing as it may take him additional time to formulate his response and that response may not always be reflective of the topic of discussion. It might sometimes be necessary to provide prompting to keep him on track with the current topic. Such prompts may additionally be required if he begins to obsess or loop over points of discussion he strongly values and or topics in which he was not given the response he wanted. Repeated, easy to understand descriptions might also be necessary when communicating with him due to his level of understanding.

- 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. Both IDTs identified only one important outcome (i.e., community employment) in the CLDP, and both included supports to engage the individual with TWC within three months and to obtain employment related to their specific employment preferences within six months. This was positive. However, based on the other documentation submitted for review, both individuals had a number of other personal desires and/or goals they wanted to achieve, but the CLDPs did not address them in an assertive manner and did not meet criterion.
    - For Individual #299, in addition to and living in a group home, the ISP proposed vision statement included taking part in community activities (i.e., Painting with a Twist) with her sisters, working part time at a greenhouse in the community, and improved reading skills, with increased independence and control over her life. It was positive her CLDP included post-move supports for community employment. However, the supports required only a once-monthly leisure activity, which might or might not include Painting with a Twist, and it did not integrate opportunities to participate in the activity with her sisters. Of note, the ISP laid out a series of action steps that would facilitate achievement of this personal goal, for her to register for on-line classes and using the computer lab on campus to see when and where the activity was offered in the community and how much it would cost, and to budget accordingly, but the CLDP did not include related supports. All of these would have been very appropriate for implementation in the community. The CLDP supports also did not address improved reading skills or independent living skills.
    - For Individual #80, the ISP vision statement included attending the Texas Showdown Gaming Tournament in Houston, unsupervised weekend visits with his sister, reading a sports-related book, living in a group home, and becoming more independent in his daily routine. Except for transitioning to a group home, the CLDP did not explicitly address any of these with post-move supports.

- Need/desire for employment, and/or other meaningful day activities: It was positive that both CLDPs addressed achievement of the individuals' employment goals and included outcome oriented post move supports for obtaining employment. Both CLDPs met criterion.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success: These CLDPs did not meet criterion. Neither CLDP identified any supports for specific positive reinforcement, although both individuals had individualized reinforcement techniques in their PBSPs.

- Teaching, maintenance, participation, and acquisition of specific skills: These two CLDPs had minimal specific supports for training objectives related to the individuals' key preferences or assessed needs and neither met criterion Findings included:
    - Individual #299's CLDP did not include any post-move supports for teaching, maintenance, participation, and acquisition of specific skills. Center staff did not submit a Functional Skills Assessment (FSA) for review. However, based on her ISP, she was working on skill acquisition programs (SAPs) for math and would benefit from reading classes when they resumed after COVID-19 precautions, and from training to use a bank account and a debit card
    - Based on the nursing assessment for Individual #80, his lack of tooth brushing was a significant concern. So, it was very positive to see that, based on her reading of the assessments, the Center Placement Coordinator identified a need for skill acquisition related to oral hygiene and encouraged the IDT to include a specific post-move support to improve his tooth brushing skills. However, the CLDP otherwise did not include any other supports for teaching, maintenance, participation, and acquisition of specific skills and did not meet criterion. Other documentation cited specific skill acquisition needs the IDT could have easily integrated, including assessment for budgeting and for use of line guide to help with reading. The ISP also recommended that he be assisted to obtain a library card.

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. It was also very positive that the Center Placement Coordinator took an active role in noting gaps or unaddressed recommendations. 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 as required and, for the most part, was done thoroughly. The comments below point to the aspects of post-move monitoring that need improvement to move to meeting criteria. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	299	80							

3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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.	N/A									
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A									

Comments:

4. The PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports in many instances, but there continued to be compromised reliability and validity. The following describes progress noted as well as continued opportunities for improvement:

- 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 reliable and valid data. 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.
- As previously noted as a concern, the CLDPs often required PMM interviews as one form of required evidence, but typically did not specify who the PMM needed to interview. The IDTs should focus on being more specific in this area. In general, the PMM should interview the provider staff who have the primary responsibility for the implementation of the respective supports, as well as the individual where feasible.
- It was very good to see the PMM made clear, concise, and thorough comments for post-move supports. Once the IDT provides the needed evidentiary guidance, this practice of documenting each of the specified requirements should lead to compliance. However, on occasion the PMM did not provide the required evidence, but marked a corresponding support as in place. The following describes examples:
    - For Individual #299, at both the seven-day and 45-day PMM visits, the PMM did not provide sufficient evidence of provider staff knowledge of her PBSP. For example, based on the PMM documentation provided for the 45-day PMM

visit, the PMM discussed management and prevention techniques with provider staff, who correctly identified Individual #299's target behaviors. However, the documentation did not address the implementation of observation checks and indicated the PMM had to provide explanations regarding management techniques for instances of verbal aggression. The PMM scored the support as in place, but should not have. It is good practice for the PMM to provide explanations when provider staff are not able to demonstrate competence, but in such circumstances, the PMM should score the support as not met.

- Individual #80 had a post-move support to have his head of bed elevated by the use of wooden blocks (i.e., provided by the Center). At the time of the seven-day PMM visit, the PMM documented that the provider was using a wedge placed between the mattress and box spring, but it was unclear this provided the required elevation, or why the blocks were not in use. The PMM marked this support as in place, but should not have based on the available evidence.
- Also, for Individual #80, at the time of the seven-day PMM visit, the PMM marked a post-move support as in place that called for the provider to assist him to obtain a state-issued identification (ID) card. The provider noted that the individual had an ID when he moved from the SSLC and the PMM based an affirmative score on that evidence and, then at the time of the 45-day PMM visit, marked the support as not applicable. However, the ID was not current and needed to be updated with his new address. It was positive, though, that after the 45-day PMM visit, the PMM did follow-up to notify the provider to assist the individual to obtain an updated ID with his new address.

5. As described above, in some instances, the Monitoring Team also could not evaluate or confirm whether individuals had received supports due to the lack of 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. In addition, based on information the Post Move Monitor collected, both individuals had gaps in receiving supports as listed and/or described in the CLDP. In many instances, but not all, the gaps could be attributed to COVID-19 restrictions. For example, attendance at day habilitation programs was delayed due to those programs being unavailable. Examples of supports not provided as written that were not attributable to COVID-19 are described with regard to Indicator 4 above for Individual #299 (i.e., staff knowledge of her PBSP) and for Individual #80 (i.e., head of bed elevation and state issued ID).

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6. Based on the supports defined in the CLDP, in most instances, the Post-Move Monitor's scoring was often correct, but there were still some supports for which the evidence provided did not clearly substantiate the finding. Examples are described above with regard to Indicator 4 and below with regard to Indicators 7 through 8.

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, which, as described with regard to Outcome 1, will require additional improvement.

Still, the Monitoring Team found some good examples of timely and completed follow-up for these two CLDPs. For example, for Individual #299, the PMM took good follow-up action to ensure medication prescriptions were available after a missed psychiatry appointment and to resolve a concern about items that were missing after her transition. For Individual #80, the PMM completed follow-up to obtain documentation showing that his weight was obtained as needed, that he had access to a gaming system, and that

provider staff implemented a tooth brushing objective. In other examples, the PMM had not documented following-up on areas of concern, or doing so through to resolution.

- While it was positive to see that the PMM documented in the PMM Checklist that she held meetings with the Center IDT to discuss areas of concern (e.g., to address provider concerns for Individual #80 that arose after his 45-day PMM visit), the Center could not provide ISPA evidence of these efforts. Going forward, Center staff should complete a formal ISPA to document who participated as well as the deliberations and decisions/action steps.
- For Individual #80, as described with regard to Outcome 3, the PMM did not document requesting that appropriate IDT members address a significant change (i.e., restricting access to tobacco dip) to his PBSP by the community BCBA that was in conflict with the IDT's recommendation to continue his current access to maintain stability. The PMM also did not document seeking IDT review of the Individual #299's revised PBSP.
- Also, for Individual #80, at the time of the 45-day PMM visit, the notes from the psychiatry consult indicated that provider staff reported he had been refusing some medications, but the PMM noted that the medication administration record showed he had no refusals. Such a discrepancy requires the PMM to investigate and document the resolution and should not have been scored as in place until that follow-up was completed.
- For Individual #80, at the time of the 45-day PMM, the PMM documented that two unmet needs were resolved, but did not provide evidence to support this conclusion. For example, Individual #80 had not attended church and had requested the opportunity to attend an African-American church with singing. Provider staff indicated they would offer an opportunity at such a church and would follow-up with the PMM. The PMM then noted the issue to be resolved, but should have marked it as pending until the follow-up information could be provided.

9-10. The Monitoring Team observed a portion of Individual #299's 45-day post-move monitoring during this monitoring visit, but was not able to observe the monitoring of supports related to nursing/health care. As a result, these indicators were not rated. However, the following feedback is offered with regard to the portion observed at the individual's home.

Overall, the PMM was very methodical and addressed every support applicable to the nature of the observation. Upon review of the PMM Checklist provided by Center staff following the remote review period, in most cases, the PMM's report was an accurate reflection of the post-move monitoring visit.

The primary exception to the above findings was with regard to the post-move support for implementation of the PBSP. Based on the documentation provided, the PMM stated she discussed management and prevention techniques with provider staff, who correctly identified Individual #299's target behaviors. However, based on observation, and as indicated in the PMM Checklist provided, the PMM had to provide explanations regarding management techniques for instances of verbal aggression. Also, provider staff stated that the primary management technique for verbal aggression was to send the individual to her room. This was not consistent with the instructions in the support and might also be in conflict with the home and community-based setting requirements regarding seclusion. In addition, the documentation did not address provider staff knowledge of management techniques for property destruction or for stealing (i.e., implementation of observation checks as needed). Even though provider staff indicated the individual had not exhibited those behaviors, it is necessary for the PMM to confirm that provider staff are knowledgeable of what to do in the event those behaviors do occur in the future. The PMM scored the support as in place, but should not have.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: One individual had no PDCT events. The other individual had two, one of which did not have sufficient supports or planning during the transition to have reduced the likelihood of its occurrence. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	299	80								
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.	67% 2/3	1/1	1/2								

Comments:

11. Individual #299 did not experience any PDCT events, while Individual #80 experienced two such events. In one instance (i.e., a traffic accident involving the provider's van that occurred on 8/6/21), it appeared the event could not have been anticipated and was not preventable. However, for the other PDCT event (i.e., law enforcement contact within 90 days of transition and elopement), the IDT had not sufficiently identified, developed, and taken actions (i.e., developed needed and measurable supports, provided requisite training and/or ensured provider staff competency) prior to the Individual #80's transition. In particular, as described with regard to Indicators 1 and 2 above, the CLDP did not include behavioral pre-move training and competency testing supports or post-move implementation supports to ensure that provider staff had adequate knowledge of the individual's target behaviors and intervention strategies.

Based upon review of the PDCT ISPA documentation, on 8/3/21, Individual #80 became upset due to not being given any additional tobacco dip for the day. He went to a cabinet and took more dip, despite staff prompts. He stated he was going to walk back to the SSLC and began walking from the home, with provider staff following. Due to his non-compliance with staff prompts to return, and possibly being in danger due to carrying a stick, provider staff called the police. Police arrived and attempted to speak with Individual #80, who refused. The police then left the scene, stating that the individual was not a danger to himself or anyone else. Individual #80 continued walking and began waving the stick at cars and making obscene gestures. At that point, provider staff again called police, who provided the same feedback and did not intervene. Although the PDCT ISPA did not document the outcome of this event, transition staff reported Individual #80 did eventually agree to return to the group home.

In reviewing the event, it was positive the IDT did have a thoughtful discussion, but they still needed to dig a little deeper to identify things they could have done differently, and could do differently in the future. The following provides examples of IDT considerations and opportunities for improvement:

- The IDT agreed they did not train on the issue of elopement because the individual did not have this history. However, a review of his history indicated he had a PBSP at one point that targeted the behavior of leaving supervision, as well as at least one similar incident when living in the community, during which he walked into traffic attempting to get struck. We again

encouraged the Center to include provider staff knowledge of behavioral history, including any related successful prevention strategies, in CLDP supports, since it is not uncommon for historical behavior to re-emerge in less restrictive community settings.

- In addition, although the PDCT ISPA indicated that Center staff provided training about Individual #80's current tobacco usage program, the behavioral competency quiz did not test staff knowledge of his behavior antecedents/setting events (i.e., as described with regard to pre-move training supports in Outcome 1 above), which included being denied and/or running out of tobacco dip. Center staff should have considered whether the training and competency testing were adequate for this purpose.
- The PDCT ISPA also noted the IDT had encouraged provider staff to continue this PBSP strategy to ensure stability, although there was no formal documentation or CLDP support that emphasized this recommendation. However, at the time of the PDCT, the provider BCBA had made changes to the PBSP that included a Tobacco Program that limited his access to tobacco to one can of chewing tobacco a day. At the time of the 45-day PMM visit on 7/7/21, 07/07/21, the PMM documented a review of the provider BCBA's plan revisions, effective 6/4/21, but Center staff did not provide any evidence that the PMM obtained a review by the IDT. This would have been important if the IDT had encouraged the provider not to make such changes. As the Monitoring Team has previously recommended, going forward, Center staff should have a clear protocol in place for IDT review of PMM results, especially when significant changes occur.
- The IDT also noted they could have met with Individual #80 to stress to him the importance of making his placement successful by providing him with reassurance and reinforcing his success thus far. This seemed to be a very positive approach Center IDTs could incorporate in the future.

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: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	299	80							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1								
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	50% 1/2	0/1	1/1								
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	50% 1/2	0/1	1/1								
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. As reported at the time of previous review, discipline assessments to support successful transitions continued to need improvement**.** The Monitoring Team considers the following four sub-indicators when evaluating compliance. The following provides a summary of the findings for this review:

- Assessments updated within 45 Days of transition: Most assessments met criterion for timeliness. Exceptions included:
  - For both individuals, the Center did not submit an updated communication assessment. However, as described with regard to Outcome 1 above, both individuals had communication strategies of which provider staff needed to be aware.
  - The medical assessment and functional skills assessments submitted for Individual #80 were dated 2/26/21, which was more than 45 days prior to his transition on 5/24/21.
  - The IDT did not provide an updated FSA for Individual #299.
- 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, for Individual #80, the OT/PT assessment, dated 4/26/21, did not include any information about a neurological consultation on 3/19/21 that indicated he had developed bilateral ulnar palsies. Based on the documentation in the nursing transition assessment, the consult indicated palsies were probably due to compression at the elbow/cubital runnel and that he would need nerve conduction testing in the near future. The consult further advised that the individual avoid bracing his elbows on tables, countertops, armrest of chairs, and so forth.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Overall, as described above with regard to Indicator 1, most discipline assessments provided minimal information with regard to pre-move training requirements, and most did not provide recommendations that would support the transition process. For pre-move training supports that Center disciplines did recommend in the

assessments, none specified the competency criteria by which provider competence could be measured. As previously reported, transition staff can provide assistance and guidance in this area, but the primary responsibility for crafting pre-move training supports will necessarily fall to the IDT members who know the person well, and this information should be reflected in their discipline-specific assessments. It was positive to see that transition staff often prompted discussion in this area to try to address this deficiency.

- 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, such as providing recommendations to help IDTs develop or modify supports that would be specific to the new community settings. For example, as reported previously, for both individuals, the psychiatric assessments did not provide individualized recommendations that focused on meeting their psychiatric needs in community settings.

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. At the time of the previous review, transition staff indicated they were working with IDT members to improve pre-move training and competency testing. It was very positive that, based on their own detailed review of one of the two transitions selected by the Monitoring Team, Center transition staff were very cognizant of the continuing needs in this area, and were developing strategies to include revamping of their training efforts, additional guidelines to IDT members prior to the 14-day ISPAs, and doing more individualized training with various disciplines. They also hoped to jump-start video training that provider staff would be able to keep for use with new staff and/or any needed re-training.

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 to whether any collaboration was needed, and, if any was completed, the statement should summarize findings and outcomes. Both CLDPs included a relevant statement indicated collaboration needs in the areas of nursing and behavioral health, but only Individual #80's IDT developed pre-move supports to ensure completion of these needed collaborations. Neither CLDP indicated why these collaborations were needed or what should be covered, and did not provide a statement with regard to whether or not any of these collaborations were completed or any results. In response to the Monitoring Team's request, Center staff indicated they did not have any evidence the required collaborations occurred for Individual #299, but provided IPNs by both Center nursing and behavioral staff for Individual #80. Overall, the documentation was very brief and uninformative. The nursing IPN consisted of two lines that very broadly indicated the content. For example, it stated it covered the topics of the individual's risk ratings and integrated health training and appointment follow-up. It was particularly unclear what information might have been conveyed with regard to the latter. The behavioral IPN also consisted of two sentences indicating the topics discussed. However, because the IDT provided only a broad expectation (i.e., current plan and behavioral history), it was not clear all needed information was conveyed. For example, as described with regard to Outcome 3 above, the IDT indicated they encouraged provider staff to continue the PBSP strategies related to tobacco use to ensure the individual's stability, but there was no

evidence provided to show how this occurred. The behavioral collaboration would have presented an important opportunity to make this recommendation.

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. For Individual #299, the CLDP stated only that no settings assessments were needed, but did not provide any rationale for that statement and did not meet criterion. For Individual #80, the CLDP met criterion. His IDT provided a more detailed narrative that stated the IDT did not identify a need for a clinical assessment of settings, given that he didn't require a specific home environment or bedroom or bathroom modifications. Going forward, though, Center staff should also consider other individual needs (e.g., behavioral) that might require a settings assessment.

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. One of two CLDPs met criterion. It was positive that Individual #80's CLDP indicated a direct support professional (DSP) spent time with him during his day visits, sharing with provider staff the best way to interact with Individual #80 and, further, that the IDT determined this to be sufficient to meet his needs. However, Individual #299's CLDP did not provide a clear statement (i.e., only stated it was "not a need") and did not meet criterion.

19. The PMSRs for both individuals were completed prior to the transition date, which was positive. It is essential, though, that the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility. Neither of these two PMSRs accomplished this and therefore did not meet criterion.. 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.

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 or refused to allow completion of all or part of the dental exam or work once at the clinic);
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- In the past six months, individuals with dental emergencies;
- Individuals with Do Not Resuscitate Orders, including qualifying condition; and
- In the past six months, individuals with adverse drug reactions, including date of discovery.

- Lists of:
  - Crisis intervention restraints.
  - Medical restraints.
  - Protective devices.
  - Any injuries to individuals that occurred during restraint.
  - 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 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