United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: June 8-12, 2015

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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 Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

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

In mid-2014, the parties determined that the facilities were more likely to make progress and achieve substantial compliance with the Settlement Agreement if monitoring focused upon a small number of individuals, the way those individuals received supports and services, and the types of outcomes that those individuals experienced. To that end, the Monitors and their team members developed sets of outcomes, indicators, tools, and procedures. These were piloted at two SSLCs in November 2014 and December 2014. Implementation began in January 2015. The first round of reviews was scheduled to occur over a nine-month period, and the parties determined that due to the extensive changes in the way monitoring would occur, compliance findings would not be made during this round of reviews. In addition, at the time of implementation, the outcomes and indicators for monitoring each SSLC's quality assurance program and some aspects of the facility's most integrated setting practices were not finalized. This was due to the State and DOJ's continued discussions regarding the most integrated setting practices, and the State's efforts to completely revise its quality assurance system.

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

are in place, and, therefore, for a group of individuals, these deeper reviews will be conducted regardless of the individuals' current outcomes.

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

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Monitoring Teams.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed. The amount of documentation requested by the Monitoring Teams decreased with the changes in the way monitoring was being conducted.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, PBSP and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. Scoring and compliance determinations – The report details each of the various outcomes used to determine compliance with each Domain, and the indicators that are used to determine compliance with each outcome. 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 case reviews. These scores will be used to make a determination of substantial compliance for each outcome. As noted above, the parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews.

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 six domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
d. **Facility self-assessment**: The parties agreed that the facility self-assessment would not be conducted for this round of reviews.
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' outcomes, indicators, tools, and procedures documents (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at San Angelo SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The facility director supported the work of the Monitoring Teams, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.		
Compliance rating:		
#	Indicator	Score
1	There has been an overall decrease in, or ongoing low usage of, crisis restraints at the facility.	57% 4/7
2	There has been an overall decrease in, or ongoing low usage of, crisis restraints for the individual.	30% 1.5/5

Comments:

1. Seven sets of monthly data were reviewed: number of crisis intervention restraints, average duration of a restraint, number of chemical crisis intervention restraints, number of mechanical crisis intervention restraints, number of restraints during which an injury occurred to the individual, number of individuals who were restrained, and number of individuals who received protective mechanical restraint for self-injurious behavior.

Data from state office and from the facility for the past nine months (August 2014 through April 2015) showed an overall increasing trend in the rate of crisis restraints (physical, chemical, mechanical) over the past five months. The average duration of a physical restraint, however, had decreased, from approximately eight minutes to approximately five minutes. The number of crisis restraints that required mechanical restraint remained at zero for all nine months, however, the number that required chemical restraint was increasing over the past seven months to 20 or more per month.

The number of these restraints during which an injury to the individual occurred had also increased to approximately 15 times per month. Overall, the number of different individuals who had received restraint was decreasing over this period, from approximately 25 per month to approximately 15 per month.

Also, the number of individuals with protective mechanical restraint for self-injurious behavior remained low and stable at two. San Angelo SSLC was effective in reducing and fading the amount of PMR-SIB for these two very challenging cases. For both individuals, the amount of protective gear was successfully and thoughtfully faded over the past years to, in these instances, lightweight gloves or wristbands. The Monitoring Team was notified that during the week following the onsite review, PMR-SIB was fully discontinued for one of these two individuals (Individual #100).

Thus, state and facility data showed low usage and/or decreases in four of these seven facility-wide measures.

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint (Individual #186, Individual #329, Individual #364, Individual #100, Individual #37, Individual #296). Data from state office and from the facility showed decreases in frequency over the past nine months for one of the six (Individual #296). Individual #100 did not show a decrease in the frequency of crisis intervention restraint, however, there was a decrease in the amount of time protective mechanical restraint for self-injurious behavior was used each month.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
3	There was no evidence of prone restraint used.	100% 11/11
4	The restraint was a method approved in facility policy.	100% 11/11
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 11/11
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 8/8
7	There was no injury to the individual as a result of implementation of the restraint.	91% 10/11
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 11/11
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	67% 6/9
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 11/11
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	36% 4/11

Comments: The Monitoring Team chose to review 11 restraint incidents that occurred for six different individuals (Individual #186, Individual #329, Individual #100, Individual #364, Individual #37, Individual #296). Of these, eight were crisis intervention physical restraints, two were crisis intervention chemical restraints, and one was a protective mechanical restraint for self-injury (gloves). The crisis intervention restraints were for aggression to staff, property destruction, and self-injury.

7. Injury occurred during restraint of Individual #186 11/22/14.

9. This indicator was not scored for the two restraints for Individual #296 because she met criterion for indicator 2 in the above outcome. Three restraints (Individual #100, Individual #364) did not meet criterion because these individuals did not have updated functional assessments and/or behavioral health assessments.

The facility was not able to maintain a stable team of psychiatrists to provide (even relatively) long-term psychiatric care and services for individuals. This was a long-standing well-known problem at San Angelo SSLC. For instance, one of the individuals, in the past year, had three quarterlies completed (not four). Each of the three was done by a different psychiatrist. Her annual psychiatric assessment was done by a fourth psychiatrist. Moreover, her most recent psychiatrist completed her locum tenens appointment during the week prior to the onsite review and was not returning, which means that this individual will have a fifth psychiatrist in a 12 (or so) month period. Inconsistent psychiatric care and services can contribute to the exhibition of psychiatric symptoms and to the occurrence of behaviors that can lead to restraint.

11. The IRRF section of the ISP had one of the two options to note restraint considerations checked for four individuals. The other seven were blank. The facility submitted a list of all individuals who have restraint contra-indications and where that information can be found. The list, however, showed that the information resided in at least eight different types of documents.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.		
Compliance rating:		
#	Indicator	Score
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 5/5
Comments: 12. All staff interviewed were very knowledgeable about this topic.		

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	82% 9/11
14	A licensed health care professional monitored vital signs and mental status as required by state policy.	100% 11/11
15	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 3/3
16	The individual was checked for restraint-related injuries following crisis intervention restraint.	100% 11/11
Comments: 13. Criterion was met for all, except two. For Individual #186 11/22/14, the restraint monitor noted no injury on the FFA, however, other documentation clearly showed that the individual was injured as a result of the restraint application. This demonstrated an incomplete assessment of restraint consequences by the restraint monitor. For Individual #364 12/29/14, the restraint monitor (who was not present during the restraint) did not interview the three staff involved in the restraint to discuss circumstances and consequences. Thus, the FFA lacked sufficient information. 14. The facility's performance on this indicator was a noticeable improvement from previous reviews.		

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.		
Compliance rating:		
#	Indicator	Score
17	Restraint was documented in compliance with Appendix A.	91% 10/11
Comments: 17. All were complete and contained all required information, except Individual #364 12/29/14 was missing one item, regarding names of staff involved. Three staff were listed, with no last name for one, and no signatures or title for any.		

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.		
Compliance rating:		
#	Indicator	Score
18	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	56% 5/9
19	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	89% 8/9

Comments:
The two restraints for Individual #296 were not included in the scoring of the two indicators in this outcome because her restraints met criterion for restraint indicators 2-11.

18-19. Four restraints did not meet criterion. For Individual #186 11/22/14, the FFA signatures indicated that unit and IMRT review occurred nine days after the restraint. For Individual #37 3/13/15, signature dates on the FFA showed unit review 10 days after the restraint. For Individual #364 3/11/15, the FFA showed review three weeks after the restraint and no review by the IMRT. For Individual #364 12/29/14, unit and IMRT reviews occurred eight days after the restraint. Subsequently, the director of training reviewed the circumstances associated with the incident and documented this in an email 1/28/15. The content was good, however, it occurred long after the restraint incident.

Abuse, Neglect, and Incident Management

Outcome 1- Individuals are safe and free from harm; and supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.		
Compliance rating:		
#	Indicator	Score
1	If there were any confirmed allegations of abuse, neglect, or exploitation, or if the individual was subject to any serious injury or other unusual incident, prior to the allegation/incident, protections were in place to reduce the risk of occurrence.	50% 3/6

Comments: For the nine individuals chosen for monitoring, the Monitoring Team reviewed 12 investigations that occurred for eight of the individuals. The other individual was not involved in any investigations. Of these 12 investigations, eight were DFPS investigations of abuse-neglect allegations (two confirmed, five unconfirmed, one inconclusive). The other four were facility investigations of unauthorized departure from the facility, serious injury, encounter with law enforcement, and sexual incident.

- Individual #329, UIR 7222, DFPS 43454678, confirmed neglect allegation, 11/25/14
- Individual #37, UIR7464, DFPS 43554805, confirmed neglect allegation, 2/23/15
- Individual #186, UIR 7521, DFPS 43582288, inconclusive physical abuse allegation, 3/18/15
- Individual #38, UIR 7217, DFPS 43451013, unconfirmed verbal abuse allegation, 11/21/14
- Individual #244, UIR 7349, DFPS 43494708, unconfirmed physical abuse allegation, 1/6/15
- Individual #100, UIR 7252, DFPS 43462265, unconfirmed physical abuse allegation, 12/3/14
- Individual #364, UIR 7505, DFPS 43574147, unconfirmed neglect allegation, 3/11/15
- Individual #296, UIR 7580, DFPS 43600312, unconfirmed physical abuse allegation, 4/2/15
- Individual #186, UIR 7198, serious incident/injury, 11/13/14
- Individual #100, UIR7560, serious injury, 3/28/15
- Individual #329, UIR 7151, unauthorized departure and law enforcement encounter, 10/24/14
- Individual #37, UIR 7410, sexual incident, 2/1/15

1. For confirmed allegations, and for occurrences of serious injury, the Monitoring Team looks to see if protections were in place prior to the confirmation or injury occurring. Six investigations were considered for this indicator (Individual #186 UIR 7198, Individual #329 UIR 7222, Individual #100 UIR 7560, Individual #364 UIR 7505, Individual #37 UIR 7464, Individual #296 UIR 7580). To assist the Monitoring Team in scoring this indicator, the facility director of incident management met with the Monitoring Team onsite at the facility.

Criminal background checks were conducted in all cases, and staff signed the annual acknowledgement of their reporting responsibilities, except for two staff in one of the cases. Trends were identified and plans were developed and implemented for three of the six cases. For Individual #329 UIR 7222 and Individual #37 UIR 7464 (confirmed neglect allegations) and Individual #100, UIR7560 (serious injury), however, protections were identified, but not implemented, to address the risks identified in DFPS reports.

For example, Individual #100 had a trend of many similar incidents (159 allegations with 18 confirmed).

Neglect confirmations from DFPS, both prior to and following this event, identified that staff were not following protocols for prevention of self-injury. Similarly, the door locking mechanism for Individual #329 was identified, but not implemented. Thus, protections that might have prevented these incidents were never fully implemented.

The facility did not have a fully adequate system in place to ensure that the protections and recommendations generated from their own reviews and analyses of trends related to individuals were being consistently implemented and that they remained in place.

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

Compliance rating:

#	Indicator	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.	83% 10/12
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	50% 2/4

Comments:

2. The Monitoring team rated two of the investigations as being reported late.
    - Individual #38 UIR 7217: The incident was reported to DFPS at 11:34 am. The UIR showed facility director notification at 1:03 pm. The director of incident management stated that facility management was made aware, but the reporting was 30 minutes late.
    - Individual #364 UIR 7505: The incident occurred at 10:15 pm. It was reported as an allegation of neglect at 4:43 pm the next day. The Monitoring Team could not determine, based on the content of the UIR, whether the reporting occurred as a result of a preliminary investigation (in which case it would not be late reporting) or if it was an independent action by one or more staff. The final review of a UIR by the facility should identify late reporting (or apparent late reporting) issues and describe the actual (or likely) circumstances as to why the incident was not reported earlier. After talking with the director of incident management, the Monitoring Team understood this case to be one of late reporting that was not documented as such in the UIR.

Also of note:

- Individual #329 UIR 7222: This incident occurred at 7:45 am and was reported to the facility director at 8:06 am. It was reported to DFPS as an allegation of neglect at 10:11 am. During discussion with the director of incident management, the Monitoring Team learned that the facility determined it should be called in as an abuse allegation and then did so. This is exactly what should happen. The UIR did not (but needs to) make this clear.
- Individual #296 UIR 7580: The incident was reported 12 days after occurrence. This case, however, was incorrectly investigated by DFPS (i.e., wrong day, home, and staff). It had to be re-entered and the investigation re-started.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and incident reporting.

Compliance rating:

#	Indicator	Score
4	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	86% 6/7

Comments:

4. One staff member incorrectly stated that allegations should reported to the home manager.

Outcome 4- Individuals and their legal representatives are educated about abuse, neglect, and reporting procedures.		
Compliance rating:		
#	Indicator	Score
5	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 7/7
Comments:		

Outcome 5- There was no evidence regarding retaliation or fear of retaliation for reporting abuse, neglect, or incidents.		
Compliance rating:		
#	Indicator	Score
6	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 12/12
Comments:		

Outcome 6 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.		
Compliance rating:		
#	Indicator	Score
7	Following report of the incident the facility took immediate and appropriate action to protect the individual.	92% 11/12
Comments: 7. For Individual #364 UIR 7505: The DFPS report named an alleged perpetrator, who was identified by the reporter, on the first page of the investigation report. In the immediate actions section of the UIR, there was no indication that any employee was removed from client contact, nor any explanation as to why a named alleged perpetrator was not removed from client contact. In this case, the allegation was about something that occurred a few weeks prior. At the allegation, the alleged perpetrator was no longer working at the facility. Even so, this information should be in the UIR.		

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	100% 12/12
Comments:		

Outcome 8 – Investigations contain all of the required elements of a complete and thorough investigation.		
Compliance rating:		
#	Indicator	Score
9	Commenced within 24 hours of being reported.	100% 12/12
10	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	92% 11/12
11	Resulted in a written report that included a summary of the investigation findings.	100% 12/12

12	Maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	100% 12/12
13	Required specific elements for the conduct of a complete and thorough investigation were present.	100% 12/12
14	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	100% 12/12
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	100% 12/12
Comments: 10. All of the investigations met criterion, except Individual #38 UIR 7217. There was an approved extension to 12/11/14, but it was not completed until 12/15/14 with no additional extension approved.		

Outcome 9 –Investigations provide a clear basis for the investigator's conclusion.		
Compliance rating:		
#	Indicator	Score
16	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 12/12
17	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 12/12
Comments:		

Outcome 10- Individuals are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation.		
Compliance rating:		
#	Indicator	Score
18	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 5/5
19	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 1/1
Comments:		

Outcome 11 –Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.		
Compliance rating:		
#	Indicator	Score
20	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 12/12
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 5/5
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 8/8
23	There was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified.	100% 9/9
Comments:		

Outcome 12 – The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.		
Compliance rating:		
#	Indicator	Score
24	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	100%
25	Over the past two quarters, the facility's trend analyses contained the required content.	100%
26	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	100%
27	As appropriate, action plans were developed both for specific individuals and at a systemic level.	100%
28	Action plans were implemented and tracked to completion.	100%
29	The action plan described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness.	100%
30	The action plan had been timely and thoroughly implemented.	100%
31	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.	100%
Comments: 24-31. The facility system for tracking, trending, and analyzing incident related data, and for developing follow-up plans, was exemplary. The facility continued to work with the challenges created by a high number of unfounded allegations. As well described by the director of incident management, this results in the temporary re-assignment of staff who are less familiar with the individuals, which then sets the occasion for mistakes in plan implementation.		

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen for review are monitored with these indicators.)		
Compliance rating:		
#	Indicator	Score
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/2
48	Multiple medications were not used during chemical restraint.	0% 0/2
49	Psychiatry follow-up occurred following chemical restraint.	0% 0/2
Comments: 47-49. These indicators were scored for chemical restraint incident for Individual #329 and Individual #364. For Individual #329, there was no psychiatrist review and for Individual #364, the review occurred two months following the restraint. Multiple medications were used; no justification was provided. There was no follow-up reported. Further, as noted in this report in Domain #3, under nursing, outcome #6, indicator #d, the Monitoring Team found the use of psychiatric medication on a PRN basis when Individual #38 refused his oral		

medications. Please see the comments under that outcome.

Pretreatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
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 information the Facility provided prior to the onsite review, none of the individuals residing at San Angelo SSLC had pre-treatment sedation (i.e., TIVA or oral pre-treatment sedation) in the year prior to the review. Of note, during the Monitoring Team's August 2014 review, it was reported that the Facility's last TIVA clinic was conducted in February 2014. During that review, several individuals had been identified who were in need of TIVA services. Once again during this review, several of the individuals under review were noted to have multiple teeth with dental caries that required restoration, but those restorations had not been completed at the time of the review. In some instances, this was related to the need for the individuals to have dental work completed in a hospital setting. Moreover, the records of some individuals under review clearly documented that no prophylactic treatment had occurred since 2013, due to the Facility's inability to provide services in a hospital setting. The responsibility of the Facility to secure hospital dentistry services had been discussed during previous reviews and in reports for several years. A positive finding was that the Facility held its first TIVA clinic since February 2014 during the week of the Monitoring Team's onsite review. It was reported that this would occur monthly and treatment for three to four individuals would be scheduled for each clinic.		

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed, including:	
	i. An interdisciplinary committee/group (e.g., individual's interdisciplinary team) determines medication and dosage;	0% 0/2
	ii. Informed consent is confirmed/present;	100% 2/2
	iii. Pre-procedure vital signs are documented.	100% 2/2
	iv. A post-procedure vital sign flow sheet or IPN(s) is completed, and if instability is noted, it is addressed.	100% 2/2
Comments: a. Based on review of the nine individuals the Monitoring Team responsible for physical health selected, one individual (i.e., Individual #38) had pre-treatment sedation for two medical treatments/appointments. There was a lack of interdisciplinary approval (e.g., IDT) of the medications and dosages used. It was positive in these two instances, informed consent was present, and pre- and post-procedures vital signs were completed.		

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS		
Compliance rating:		
#	Indicator	Score

1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	0% 0/1
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	100% 1/1
3	Action plans were implemented.	100% 1/1
4	If implemented, progress was monitored.	0% 0/1
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1

Comments:
1. Of the nine individuals considered for this outcome, only Individual #38 had received pretreatment sedation. His ISP addressed the use of PTS, but did not include recommendations for the upcoming year.

2-5. Strategies were developed and implemented, but progress was not monitored and progress could not be determined.

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.		
Compliance rating:		
#	Indicator	Score
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 1/1
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 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
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/1
e.	Recommendations are followed through to closure.	N/A

Comments: a. Between June 1, 2014, and May 31, 2015, two individuals from San Angelo SSLC died. The Monitoring Team reviewed records for one individual who died (i.e., Individual #345), whose causes of death were listed as multi-organ failure, malnutrition, major depression, and proximal left femur fracture. Timely death reviews were completed for Individual #345.

b. through d. A number of issues related to the death of Individual #345 were not addressed in the recommendations, but should have been. Some examples include:

- Recommendations did not appear to sufficiently address the magnitude of the nursing continuity of care issues associated with the death. For example, they did not address assessments/data collection, and staff education to address/monitor subtle signs, and symptoms of illness (e.g., dehydration).
- The findings and concerns in the various reviews did not all translate into recommendations in the Administrative Death Review. Specifically, the Medical Director had concerns about the lack of psychiatric services at the Facility and how that impacted management of depression, which

contributed to the individual's poor intake, malnutrition and subsequent demise.

- There were generic comments related to IPN legibility and the challenges it presented in conducting record reviews. The Administrative Death Review should have clearly noted which disciplines had issues and corrective action plans should be targeted to those disciplines.

e. The Administration Death Review meeting was held on 6/4/15. The Facility's policy allows for 30 days to complete the recommendations.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.		
Compliance rating:		
#	Indicator	Score
a.	ADRs are reported immediately.	100% 1/1
b.	The Pharmacy and Therapeutics (P&T) Committee thoroughly discusses the ADR.	0% 0/1
c.	Clinical follow-up action is taken, as necessary, with the individual.	0% 0/1
d.	Reportable ADRs are sent to MedWatch.	N/A

Comments: The Monitoring Team reviewed the following individuals' medical records: Individual #38, Individual #140, Individual #104, Individual #71, Individual #66, Individual #76, Individual #202, Individual #215, and Individual #186. Facility staff identified one ADR for Individual #76.

Of concern, there were potentially other ADRs that went unreported. For example, one IPN entry for Individual #38 indicated that his anemia was multi-factorial and due in part to medications. If so, this should have been reported as a suspected ADR.

b. The last P&T Committee Meeting held with necessary members was during the Monitoring Team's last review, on 8/21/14. A meeting held on 2/27/15, but did not have a quorum with only four attendees present.

c. Individual #76 developed a rash, and Augmentin was suspected and discontinued. The rash resolved. Per the ADR form, Augmentin was to be added to the allergy list, but did not appear on his recent physician orders as an allergy.

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.		
Compliance rating:		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	0% 0/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2

Comments: a. and b. San Angelo SSLC had not completed any DUEs in the six months prior to the Monitoring Team's review.

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.		
Compliance rating:		
#	Indicator	Score
1	The ISP defined individualized personal goals for the individual based on the individual's preferences, strengths, and personal goals.	0% 0/6
2	The personal goals are measurable.	17% 1/6
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	17% 1/6

Comments: The monitoring reviewed six individuals to monitor the ISP process at the facility: Individual #186, Individual #38, Individual #76, Individual #202, Individual #153, and Individual #37. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings at San Angelo SSLC.

1. None of the individuals had a full array of individualized, measurable goals as appropriate to his or her needs and preferences. For example, four of the individuals had the identical living option goal "to live in the most integrated setting consistent with his/her preferences, strengths, and needs." Individual #153 and Individual #37 had more personalized goals across more areas of life, including ones that stated their specific preferences for where they would like to live.

2. Many goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting outcomes had been achieved. Goals did not identify preferences for specific day activity or living options and did not offer an opportunity to learn new skills. The actual preferences of individuals were not described and did not appear to form the basis for the establishment of the goals. For the most part, outcomes remained unchanged from the previous ISP and addressed compliance with routines at the facility rather than the acquisition of new skills. Of the six individuals, only Individual #37's goals were in acceptable measurable terminology.

3. Reliable and valid data to determine progress on goals were not available for most action plans. Monthly reviews of services and supports noted gaps in implementation and data collection for five of six individuals reviewed (all but Individual #37). In some cases, it was noted that goals were never fully implemented during the ISP year.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.		
Compliance rating:		
#	Indicator	Score
8	ISP action plans support the individual's personal goals.	0% 0/6
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6
10	ISP action plans supported how they would support the individual's overall	0%

	enhanced independence.	0/6
11	ISP action plans integrated individual's support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6
12	ISP action plans integrated strategies to minimize risks.	33% 2/6
13	ISP action plans integrated encouragement of community participation and integration.	17% 1/6
14	ISP action plans were written so as to be practical and functional both at the facility and in the community.	0% 0/6
15	ISP action plans were developed to address any identified barriers to achieving outcomes.	0% 0/6
16	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6
17	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet identified needs and personal goals.	0% 0/6
18	The ISP provided sufficient detailed information to ensure data collection and review were completed as needed for all ISP action plans.	0% 0/6

Comments: In order to develop action plans to address personal goals, IDTs will have to define what the individual would like to achieve and then develop action steps to support the individual to achieve his or her personal goals.

8. The action plans generally related to the personal goals. In some cases, however, it was not clear why the specific action step was prioritized based upon the content of the individual's assessments.

9. Individual #76's ISP minimally integrated his preferences into action plans. Overall, individuals had limited opportunities to learn new skills based on their identified preferences. For example, Individual #186's PSI noted that she would like to work in the community, cooking and washing dishes. Her vocational goals, however, were focused on addressing her refusal to attend the workshop, that is, with no consideration of matching a job to her preferences. Her PSI also noted that she wanted to learn to read and write. This was not addressed in her ISP. ISPs offered few opportunities for choice. Individual #37's ISP included a good list of his preferences, however, his action plans did not integrate his preferences. Some ISPs noted that the individual's preferences were unknown, particularly when discussing living options. Supporting individuals to make choices and express preferences would be a first step in the IDT determining individual preferences for living options.

10. Individuals did not have action plans that addressed skills needed to increase independence based on the content of their assessments and the findings in those assessments.

11-12. ISPs did not integrate all support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs. While there was usually a description of communication, OT, PT, and psychiatric supports in the ISP, ancillary plans were rarely integrated into the goals and action plans in a meaningful way. All individuals had an IHCP to address risks, however, supports to address risk were not typically integrated into other parts of the ISP. The ISPs for Individual #153 and Individual #37 contained better examples of plans to address risks.

13. Individual #76 had action plans that focused on community activities based on his preferences. Overall, however, there was a lack of focus on specific plans for community participation that would have promoted any meaningful engagement or integration.

15. The Monitoring Team identified barriers to achieving outcomes for all six individuals that were not addressed in the ISP. Often, the IDT identified barriers to achieving outcomes that were in the previous ISP, but then continued the outcome in the current ISP without addressing the barriers. For example, the IDT failed to address barriers to implementation of Individual #38 and Individual #76's community participation goals that were not correctly or regularly implemented.

16-17. None of the ISPs integrated preferences for day programming into action plans. Action plans typically were written for compliance with attendance at the options offered at the facility, but with little consideration of what the individual wanted to learn or do during the day. Individual #186's vocational assessment indicated that she enjoyed working and learning new jobs, however, her action plans addressed refusals to work without considering job exploration to determine what type of work she might prefer. Individual #38 and Individual #202 had action plans to attend the Suzy Crawford Center. There was no documentation of discussion regarding how this related to their preferences or what training would occur.

18. All ISPs included general instructions for documentation and identified who was responsible for implementation and review. ISPs did not include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs did not provide sufficient detailed instruction for monitoring.

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

Compliance rating:

#	Indicator	Score
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	50% 3/6
20	The ISP included a complete statement of the opinion and recommendation of the IDT's staff members as a whole.	100% 6/6
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6
22	The determination was based on a thorough examination of living options.	67% 4/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	83% 5/6
24	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	33% 2/6
25	ISP action plans defined an individualized and measurable plan to educate the individual/LAR about community living options.	20% 1/5
26	The IDT developed appropriate action plans to facilitate the referral if no significant obstacles were identified	N/A

Comments:

19. Three of the six ISPs included a description of the individual's preference and how that was determined. For Individual #38, Individual #76, and Individual #202, the ISP indicated that their living preferences were unknown. All three individuals had lived at the facility for a number of years. Staff should know them well enough to develop a list of preferences and support needs related to living options.

22. Two of the ISPs (Individual #38 and Individual #76) did not document discussion regarding living options that were, or might be, available and that might provide appropriate supports based on the individual's preferences and needs. Both IDTs determined that their medical needs could not be met in the community, however, they did not state which medical needs could not be met.

24. Four of the ISPs included action plans that were very general in nature and unlikely to adequately address the barriers to referral. Individual #153 and Individual #37 had specific plans to address behaviors that were identified as barriers to community placement.

25. All ISPs included a general action plan to offer information to the individual/LAR, if interested. Only one of the action plans was specific enough to be beneficial. It was clear that the team offered general information to all individuals and LARs on an annual basis. Information, however, did not appear to include specific information on how the individual's preferences and needs might be supported in other living environments. IDTs should consider focusing on individualized options that are available and could support each individual's needs.

26. None of the individuals were referred for community placement.

Outcome 5: The individual participates in informed decision-making to the fullest extent possible.		
Compliance rating:		
#	Indicator	Score
27	The individual made his/her own choices and decisions to the greatest extent possible.	0% 0/6
28	Supports needed for informed decision-making were identified through a strengths-based and individualized assessment of functional decision-making capacity.	0% 0/6
29	The individual was prioritized by the facility for assistance in obtaining decision-making assistance (usually, but not always, obtaining an LAR), if applicable.	100% 2/2
30	Individualized ISP action plans were developed and implemented to address the identified strengths, needs, and barriers related to informed decision-making.	0% 0/6

Comments:
27. None of the ISPs thoroughly documented discussion on how the team could support the individual to make decisions and exercise more control over his or her life.

28. A strength-based and individualized assessment to help guide the IDT to provide supports in this regard was not yet in place.

30. A Human Rights Committee meeting was observed during the onsite visit. The committee members engaged in excellent discussion regarding offering training opportunities to individuals that might lessen the need for restriction of certain rights (e.g., money management training). The ISPs, however, did not include action plans focused on skill building to address barriers to informed decision making.

Outcome 6: ISPs current and participation.		
Compliance rating:		
#	Indicator	Score
1	The ISP was revised at least annually.	100% 6/6
2	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A
3	The ISP was implemented within 30 days of the meeting or sooner if indicated.	50% 3/6
4	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6
5	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6

Comments:
3. Based on the Monitoring Team's review of data collection documentation and QIDP monthly reviews, all required components of the ISPs were not implemented within 30 days for Individual #38, Individual #76, and Individual #202.

4. There was evidence that five of the six individual attended the annual ISP development meeting. The exception was Individual #186.

5. LARs for two of the four individuals with LARs participated in the ISP. QIDPs for the individuals were interviewed by the Monitoring Team and found to be generally knowledgeable of individuals' preferences, strengths, and needs. There were some important IDT members, however, not in attendance at the annual IDT meeting for five of the six individuals.

- The psychiatrist, nurse, PCP, DSP, and dietician did not attend the ISP meeting for Individual #186. Given her complex needs, an interdisciplinary discussion that included all team members would be beneficial to ensure that all supports were integrated into her ISP.
- Individual #38's psychiatrist did not attend his meeting and did not submit an assessment for review by other team members.
- Individual #76's LAR did not attend his meeting.
- The PCP, psychiatrist, and dietician did not attend Individual #202's meeting.
- Individual #153's psychiatrist, PCP, and DSP did not attend his annual ISP meeting. Without input from those team members, it was unlikely that supports were comprehensive to meet his needs.

Outcome 7: Assessments and barriers		
Compliance rating:		
#	Indicator	Score
6	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
7	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6

Comments:
6-7. All individuals had an ISP preparation meeting that identified assessments recommended by the IDT and, for the most part, the team obtained recommended assessments. The rationale for determining which assessments would be required was not, however, always clear. Strengths, preferences, and needs were listed in most of the assessments, however, rarely integrated into recommendations for support. Some assessments were not available for each of the individuals prior to the meeting.

Outcome 8: Review of ISP		
Compliance rating:		
#	Indicator	Score
8	The IDT reviewed and revised the ISP as needed.	0% 0/6
9	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6

Comments:
8. IDTs met when the individual experienced some type of regression or change in status, but it was not evident that IDT members regularly reviewed supports and took action as needed when individuals experienced regression.

- Individual #186's QIDP monthly reviews showed regression towards meeting her outcomes January 2015 through March 2015. The IDT met in March 2015 to review her refusals to attend programming. The only action taken was to remind her of the importance of going to her classes and sessions. During the monitoring visit, it was reported that she was still refusing to attend programming.

- Individual #38, Individual #76, Individual #153, Individual #202, and Individual #37 did not have consistent monthly reviews of their action plans. It appeared that many of action plans were not being implemented and no action was taken by the IDT to ensure implementation.

For five individuals, assessments were not updated as needed or as recommended by the IDT.

- Individual #186 and Individual #38 did not have an updated QDDR.
- Individual #76's IDT recommended an updated SLP evaluation within 30 days of the ISP meeting and lab work to rule out rheumatoid arthritis. QIDP monthly reviews did not document that the assessments were obtained or reviewed by the IDT.
- Individual #202 showed regression in mobility during the past year. The IDT recommended an updated OT/PT assessment. It was recently completed, but not timely.
- Individual #153 had made significant progress in his mobility over the past year. His OT/PT assessment no longer reflected his current status or supports needed. It had not been updated.

9. Services and supports were not being monitored and reviewed. For the most part, monthly reviews were a summary of services without documentation of action taken by the QIDP to follow-up on issues.

Outcome 1 – Individuals at-risk conditions are properly identified.		
Compliance rating:		
#	Indicator	Score
a.	The individual's risk rating is accurate.	22% 4/18
b.	The individual's risks are identified timely.	100% 18/18

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #186 – fluid imbalance, and infections; Individual #38 – infections, and other - pain; Individual #140 – infections, and respiratory compromise; Individual #104 – UTIs, and gastrointestinal problems; Individual #71 – skin integrity, and gastrointestinal problems; Individual #66 – seizures, and constipation/bowel obstruction; Individual #76 – fluid imbalance, and constipation/bowel obstruction; Individual #202 – respiratory compromise, and infections; and Individual #215 – fluid imbalance, and respiratory compromise).

a. The individuals' risk ratings that were accurate were those for Individual #66 for seizures, Individual #71 for skin integrity and gastrointestinal problems, and Individual #104 for gastrointestinal problems.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
4	The individual has goals/objectives related to psychiatric status.	0% 0/9
5	The psychiatric goals/objectives are measurable.	0% 0/9
6	The goals/objectives are based upon the individual's assessment.	0% 0/9
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9

Comments:
4-7. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric

disorder and that also provided measures of positive indicators related to the individual's functional status. These goals will need to be formulated in a manner that makes them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined.

Some individuals had psychiatry-related goals, however, they were related to staff actions, such as behavioral health services to discuss depression with psychiatry due to crying (Individual #186), complete a CPE (Individual #329), or monitor medications and their side effects (Individual #244, Individual #100); or to the reduction of problem behaviors. Goals also need to address the symptoms of psychiatric disorder.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.		
Compliance rating:		
#	Indicator	Score
12	The individual has a CPE.	78% 7/9
13	CPE is formatted as per Appendix B	29% 2/7
14	CPE content is comprehensive.	14% 1/7
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	67% 2/3
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.	67% 6/9

Comments: This outcome relates to CPE timeliness, content, and quality.
12. CPEs were in the record for all of the individuals, except Individual #186 and Individual #153. Individual #244's was completed while she was at the Abilene SSLC. Because Individual #244 was re-admitted from a failed community placement, the facility should have considered re-doing her CPE so that it reflected her experience in the community (e.g., psychiatric disorder symptoms, behavioral incidents, medication changes).

13. Individual #244's and Individual #37's CPEs met criterion for being in Appendix B format.

14. The Monitoring Team looks for 14 components in the CPE to be present and of adequate content. Individual #244's document was complete. Individual #37's was well written; it was missing one item: a review or discussion of laboratory values. The others were missing from two to four of the components. Most often missing or incomplete were a bio-psycho-social formulation and a review or discussion of laboratory values.

15. Individual #364's IPN was done two days after admission.

16. Criterion was met for six of the nine individuals, that is, not for Individual #186, Individual #38, and Individual #329.

Outcome 5 – Individuals' status and treatment are reviewed annually.		
Compliance rating:		
#	Indicator	Score
17	Status and treatment document was updated within past 12 months.	100% 9/9
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g.,	0%

	annual psychiatry CPE update, PMTP).	0/4
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	44% 4/9
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	22% 2/9
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	11% 1/9

Comments: This outcome covers the annual updates that are prepared specifically for the ISP.
17. If an individual was a new admission and/or if the individual's CPE was completed within the past 12 months, this indicator was scored as meeting criterion.

18. This indicator applied to Individual #186, Individual #329, Individual #244, and Individual #153. The Monitoring Team scores 16 aspects of the annual document. There were from two to 12 items missing or incomplete in these annual documents.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.		
Compliance rating:		
#	Indicator	Score
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A

Comments:
22. PSPs were not utilized for any of these individuals.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.		
Compliance rating:		
#	Indicator	Score
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9
29	The written information provided to individual and to the guardian was adequate and understandable.	22% 2/9
30	A risk versus benefit discussion is in the consent documentation.	11% 1/9
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9
32	HRC review was obtained prior to implementation and annually.	100% 9/9

Comments:
29. For Individual #244 and Individual #329, there was basic information included in the consents with regard to medication side effects, and for Individual #244, the consent was completed by the psychiatrist. Individual #186 was reported to be her own agent for consent, but the form designated that she did not have the capacity to consent. Even so, she signed the forms and her consent was accepted. Individual #100's consent did not address all possible risks, such as liver problems that can result from Depakote, and kidney issues that can result from Lithium. Individual #37's did not discuss possible tardive dyskinesia risk from Invega. Individual #153's did not discuss risk of leukopenia from Clozaril.

30-31. Details regarding the individual were not given.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 9/9
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9
4	The goals/objectives were based upon the individual's assessments.	67% 6/9
5	Reliable and valid data are available that report/summarize the individual's status and progress.	11% 1/9
Comments: 1. Of the 16 individuals reviewed by both Monitoring Teams, all who required PBSPs had PBSPs. 2-3. All PBSPs reviewed had objective goals and all of them were measurable. 4. Some of PBSP goals and objectives were not consistent with those found in the functional assessment (Individual #37, Individual #153). Individual #364 did not have a functional assessment. 5. Of the nine individuals reviewed, only Individual #186 had IOA data indicating that the PBSP data were valid and reliable.		

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	67% 6/9
12	The functional assessment is current (within the past 12 months).	56% 5/9
13	The functional assessment is complete.	78% 7/9
Comments: 11. The majority of annual behavioral health assessments were current and complete. Individual #364 did not have an annual behavioral health assessment. Individual #296 and Individual #153's were missing a review of adaptive functioning. 12. Five of the functional assessments were current. Two were more than one year old (Individual #37, Individual #100), one was dated within the past year, but the direct and indirect assessment components were more than one year old (Individual #186), and one was not done (Individual #364). 13. Individual #153's did not have a clear summary, and there was not one for Individual #364.		

Outcome 4 – Quality of PBSP		
15	The PBSP was current (within the past 12 months).	78% 7/9
16	The PBSP was complete, meeting all requirements for content and quality.	33% 3/9
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	78% 7/9

Comments:
15. The PBSPs for Individual #37 and Individual #100 were not current.

16. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Although only three PBSPs were scored as complete (Individual #244, Individual #329, Individual #153), the majority of the 13 components were found in all of the PBSPs. The most common component that was incomplete was the reinforcement and training of replacement behavior. An attempt to replace a target behavior with an acceptable way (e.g., verbal request) to obtain desired staff attention, or avoid an undesired situation can be an important component of an effective PBSP. Several of the PBSPs (e.g., Individual #296, Individual #38), however, did not have clear instructions for staff when to reinforce replacement behavior and what to do when they could not be reinforced (e.g., medical demands, staff can not immediately respond). Additionally, some of the identified replacement behaviors did not appear to be functional (e.g., Individual #37, Individual #186) with no rationale provided as to for why a functional replacement behavior was not used.

Outcome 7 – Counseling		
Compliance rating:		
#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 5/5
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 5/5

Comments:
24-25. Five individuals reviewed received counseling services. For all five, treatment plans and progress notes were judged to be complete.

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment; and no older than 365 days.	89% 8/9
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	0% 0/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	83% 15/18

f.	Individual receives quality quarterly medical reviews.	0% 0/9

Comments: a. through c., and f. Of the nine individuals reviewed (i.e., Individual #38, Individual #140, Individual #104, Individual #71, Individual #66, Individual #76, Individual #202, Individual #215, and Individual #186), none was newly admitted. For the individuals reviewed, the AMA that was not completed timely was for Individual #71, for whom almost two years lapsed between medical assessments (i.e., 6/10/13 and 4/20/15). It was concerning that none of the individuals reviewed had quarterly assessments completed.

d. As applicable, aspects of the annual medical assessments that were consistently good included social/smoking histories, past medical histories, interval histories, allergies or severe side effects of medications, and lists of medications with dosages at the time of the AMA. Problems varied across annual medical assessments, but most annual medical assessments included pre-natal histories, complete physical exams with vital signs, pertinent laboratory information, and plans of care for each active medical problem, when appropriate. Areas that were particularly problematic included family history; childhood illnesses; review of associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable; and updated active problem lists

The AMA template was revised to include a medical risk assessment chart. This chart included the risks addressed in the IRRF and similarly provided recommendations each risk as high, medium or low. Unfortunately, the PCPs only provided a rating and did not include any discussion related to mitigation of risks or plan to address the risks.

e. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. The diagnoses for which justification could not be found were asthma for Individual #215, and asthma/chronic obstructive pulmonary disease (COPD) and iron deficiency anemia for Individual #38.

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

Compliance rating:

#	Indicator	Score
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.	28% 5/18

Comments: a. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #38 – respiratory compromise, and other: anemia; Individual #140 – diabetes, and respiratory compromise; Individual #104 – diabetes, and gastrointestinal problems; Individual #71 – osteoporosis, and diabetes; Individual #66 – other: vitamin D deficiency, and seizures; Individual #76 – other: vitamin D deficiency, and other: hypothyroidism; Individual #202 – other: Chronic Hyponatremia, and other: metabolic syndrome; Individual #215 –respiratory compromise, and other: hyperthyroidism; and Individual #186 – seizures, and dental).

The ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #104 – gastrointestinal problems; Individual #71 – osteoporosis, and diabetes; Individual #66 – seizures; and Individual #186 – seizures. Frequently, IHCPs did not reflect the medical contributions to the individuals' ongoing care and treatment, and, as noted above, AMAs sometimes did not set forth detailed plans of care for chronic diagnoses and/or at-risk conditions.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.		
Compliance rating:		
#	Indicator	Score
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.	44% 4/9
	iii. Individual receives annual dental summary (ADS) no later than 10 working days prior to the annual ISP meeting.	89% 8/9
b.	Individual receives a quality dental examination.	22% 2/9
c.	Individual receives a quality dental summary.	0% 0/9

Comments: a. The four individuals with timely dental examinations were Individual #71, Individual #202, Individual #215, and Individual #186. Except for Individual #38, individuals reviewed had timely ADSs. Some examples of problems noted were:

- Per the ADS completed on 4/14/15, Individual #38 had not seen a dentist since 2013. He needed hospital dentistry. It was not clear who completed the ADS because it was not signed. However, the assessment of oral health was based on an examination done in early 2013.
- Individual #104 had gone almost two years between dental examinations (i.e., 3/19/13 and 1/28/15). Similarly, Individual #66 had a lapse of two years between dental examinations (i.e., 1/7/13 and 1/15/15).

b. As noted above, Individual #38 did not have an up-to-date dental examination in that the last one was completed in 2013. The dental exams for Individual #186 and Individual #202 included all of the necessary elements. The remaining dental exams reviewed included many of the required elements. On a positive note, as applicable, all the remaining dental exams documented, as applicable, information about the individual's cooperation, an oral hygiene rating completed prior to treatment, information about oral cancer screening, information about sedation use, a description of the individual's last x-rays and the type of x-rays, a description of periodontal condition, odontograms, caries risk and periodontal risk, treatment provided, and treatment plans. Problems varied across exams reviewed. However, some examples of the problems noted were dental examinations that were missing periodontal charting, and the recall frequency. The biggest concern was that most did not include the number of teeth present/missing.

c. For Individual #38, the information used to complete the 4/14/15 ADS was out-of-date in that he had not had a dental exam since 2013. The Dental Assistant, who was unqualified to complete an ADS, completed Individual #186's ADS. All remaining dental summaries were missing one or more of the required elements. Issues varied across dental summaries, but some of the common problems were missing recommendations related to the need for desensitization or other plan, missing information about the number of teeth present/missing, lack of identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health, lack of a description of effectiveness of pre-treatment sedation, a lack of documentation of the provision of oral hygiene instructions to staff and the individual, no or insufficient recommendations for the risk level for the IRRF, missing descriptions of the treatment provided, insufficient dental care recommendations, and incomplete treatment plans, including the recall frequency.

Some concerns noted included:

- The ADS now included a recommendation chart that addressed a number of issues including: prophylaxis, extractions, restorations, partials, radiographs, sedation, suction tooth brushing, oral

health SAPs, and weekly tooth brushing. These charts were often left blank rather than having N/A filled in, which made it difficult to determine if items in the chart were overlooked, or did not apply to the individual.

- Additionally, the Dental Assistant sometimes completed the ADS (e.g., for Individual #186). Completion of any assessments for the IDT's use in preparation for the ISP by staff without the correct credentials is not appropriate. These assessments included the equivalent of treatment plans, and often included statements regarding professional opinions about the availability of services and supports in the community. During the onsite review, the new Dental Director indicated that moving forward the dentists would complete the ADSs.
- The Facility's data related to individuals' refusals of dental care was inaccurate. For example, Individual #104 was not listed in the pre-review documents regarding refusals, but his ADS listed two refusals, and the dentist documented multiple missed appointments.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.		
Compliance rating:		
#	Indicator	Score
a.	Individuals have timely nursing assessments:	
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	78% 7/9
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	56% 5/9
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18
c.	If during the review period, 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.	N/A

Comments: a.ii. and a.iii. Individuals reviewed that did not have timely annual comprehensive nursing record reviews were Individual #215, and Individual #76. Individuals reviewed that did not have timely quarterly nursing assessments or the assessments were incomplete were Individual #215, Individual #76, Individual #140, and Individual #186.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #186 – fluid imbalance, and infections; Individual #38 – infections, and other - pain; Individual #140 – infections, and respiratory compromise; Individual #104 – UTIs, and gastrointestinal problems; Individual #71 – skin integrity, and gastrointestinal problems; Individual #66 – seizures, and constipation/bowel obstruction; Individual #76 – fluid imbalance, and constipation/bowel obstruction; Individual #202 – respiratory compromise, and infections; and Individual #215 – fluid imbalance, and respiratory compromise). The annual comprehensive nursing assessments did not contain reviews of them that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. For the 18 risk areas reviewed for nine individuals, the individuals did not experience changes of status

during the six-month period reviewed.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP, including the integrated health care plan (IHCP), includes nursing interventions that address the chronic/at-risk condition.	0% 0/18
b.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18
c.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18
d.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18
e.	The IHCP action steps support the goal/objective.	0% 0/18
f.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18
g.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18
Comments: a. through g. Problems seen across IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.		

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns are referred to the Physical and Nutritional Management Team (PNMT) as needed, and receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.		
Compliance rating:		
#	Indicator	Score
a.	If individual has PNM issues, individual is referred to or reviewed by the PNMT as appropriate.	0% 0/7
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	0% 0/7
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	0% 0/7
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/7
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	13% 1/8
f.	As appropriate, a Registered Nurse (RN) Post Hospitalization Assessment is completed, and the PNMT discusses the results.	67% 2/3
g.	Individuals receive review/assessment with the collaboration of disciplines	0%

	needed to address the identified issue.	0/8
h.	If a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on 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% 0/8
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5

Comments: a. through e., g., h., and i. Of the nine individuals reviewed, seven individuals had qualifying events (i.e., Individual #76 – aspiration pneumonia, Individual #66 – aspiration pneumonia, Individual #215 - falls, Individual #140 - cellulitis, Individual #104 – aspiration (i.e., as reported in the OT/PT assessment, dated 2/16/15), Individual #202 - falls, and Individual #71 - falls). None of these individuals was referred to the PNMT in a timely manner. At a minimum, the PNMT should have reviewed Individual #140 and Individual #202's changes of status to determine the need for a comprehensive PNMT assessment. The remaining individuals experienced events that should have triggered comprehensive assessments, but the PNMT did not conduct such assessments. Individual #38 had a qualifying event prior to the review period, and was discharged in January 2015 after having a PNMT assessment.

In its comments on the draft report, the State indicated that: "PNMT minutes not requested in records request." The Monitoring Team included a request of PNMT meeting minutes in document request #69.

f. For Individual #66 and Individual #38, the PNMT RN completed timely post-hospital reviews, which the PNMT reviewed. The Monitoring Team found no evidence that the PNMT reviewed the post-hospital review for Individual #76.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.		
Compliance rating:		
#	Indicator	Score
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	11% 2/18
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	11% 2/18
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	67% 6/9
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	11% 2/18
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	28% 5/18
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	44% 8/18

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues for nine individuals. These included goals/objectives related to: respiratory compromise, and choking for Individual #76; choking, and falls for Individual #186; aspiration, and fractures for Individual #66; aspiration, and skin integrity for Individual #38; circulatory, and falls for Individual #215; circulatory, and falls for Individual #140; aspiration, and falls for Individual #104; choking, and falls for Individual #202; and falls, and choking for Individual #71.

a., b., and d. Generally, ISPs/IHCP did not sufficiently address individuals' PNM needs. Overall, many strategies and interventions were missing, including but not limited to preventative strategies, and methodologies to address the etiology of the issue often were not included. The two action plans that did address individuals' needs were those for falls for Individual #140, and falls for Individual #202.

c. The nine individuals reviewed had or should have had PNMPs. The following individuals' PNMPs included all of the necessary components: Individual #76, Individual #66, Individual #38, Individual #140, Individual #104, and Individual #71. For Individual #215, the Facility did not submit a PNMP. Her current ISP indicated that no supports were indicated, because the 24 falls she experienced were related to medications. It appeared that, at a minimum, supports should have addressed her safety related to falls.

f. Those that defined individualized triggers, and actions to take when they occur were the ones for aspiration for Individual #66; aspiration, and skin integrity for Individual #38; aspiration for Individual #104; and choking for Individual #202.

g. At times, IHCPs included no effectiveness monitoring, and in other instances, it was mentioned, but with no clear due dates or frequency. Those that identified the frequency of monitoring/review of progress were those for choking for Individual #186; aspiration, and fractures for Individual #66; aspiration, and skin integrity for Individual #38; falls, and choking for Individual #71, and aspiration for Individual #104.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	89% 8/9
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9
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: a. Vision, hearing, and other sensory input; b. Posture; c. Strength; d. Range of movement;	N/A

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

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #38, Individual #140, Individual #104, Individual #71, Individual #66, Individual #76, Individual #202, Individual #215, and Individual #186), none was newly admitted. It was positive that the individuals reviewed generally had timely OT/PT assessments. The exception was Individual #215, for whom no evidence was found of an assessment/update in 2014.

e. All of the individuals reviewed had updates/assessments of current status completed. Problems were noted with all updates, and the problems varied across assessments. The following summarizes the strengths of the evaluation updates as well as areas requiring focus:

- All of the applicable assessments included:
  - If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes in the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).
- Most assessments included, as applicable:
  - Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
  - Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
  - Functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
  - 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; and
  - Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment, positioning supports), including monitoring findings.
- Problems were noted with inclusion of:
  - Use of individual preferences, and strengths in developing OT/PT supports;
  - Discussion of changes to medications that might be pertinent to the problem, and a discussion of relevance to OT/PT supports and services;
  - Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
  - As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	56% 5/9
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and	67%

	updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	6/9
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	0% 0/6
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/5
Comments: a. The ISPs that provided good descriptions of the individuals' functioning from an OT/PT perspective were for Individual #76, Individual #186, Individual #140, Individual #104, and Individual #202. b. IDTs reviewed and updated PNMPs and/or Positioning Schedules at least annually for the following: Individual #76, Individual #186, Individual #66, Individual #38, Individual #202, and Individual #140. c. and d. The strategies, interventions, and programs that were not reflected in the ISPs/ISPAs were the procedures for safe eating for Individual #76, safe eating for Individual #38, supports to address Individual #215's PNM needs, Individual #71's PNM supports, and Individual #140's bathing and walking SAPs. In addition, for Individual #202, per her ISP, an assessment related to weight-bearing was to be completed within 14 days of the ISP meeting. First, it was not clear why this was not identified as a need during the Pre-ISP Meeting, and sufficiently addressed in the OT/PT annual assessment completed for the ISP. Secondly, there was no evidence that this was completed as no evidence was found in the IPN documentation.		

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	56% 5/9
b.	Individual receives assessment in accordance with their individualized needs related to communication.	33% 3/9
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: a. Vision, hearing, and other sensory input; b. Assistive/augmentative devices and supports;	0% 0/3

	• Discussion of medications being taken with a known impact on communication; • Communication needs [including AAC, Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	
d.	Individual receives quality Comprehensive Assessment.	0% 0/2
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/5

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #38, Individual #140, Individual #104, Individual #71, Individual #66, Individual #76, Individual #202, Individual #215, and Individual #186), none was newly admitted. Those individuals that did not have timely updates or comprehensive assessments included Individual #76, Individual #186, Individual #38, and Individual #71. In addition, Individual #104, and Individual #202 received updates, but should have received comprehensive assessments, because the last assessments in their records were from 2011 and 2012, respectively, with no evidence of updates in the interim.

c. The screenings for Individual #215, Individual #140, and Individual #76 did not address pertinent diagnoses.

d. and e. Two individuals (i.e., Individual #186, and Individual #76) reviewed should have had comprehensive assessments, but did not. For Individual #186, the Monitoring Team reviewed the 6/17/14 ISP, for which no communication assessment was available. For Individual #76, the communication screening indicated a comprehensive assessment was needed within 30 days, but the SLP had not completed it. The following individuals had communication updates: Individual #66, Individual #38, Individual #104, Individual #202, and Individual #71. Problems varied across assessment updates. However, based on problems seen in the various assessments of the individuals reviewed, moving forward, the Facility should ensure communication assessments and updates address, and/or include updates, as appropriate, regarding:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- Use of individual preferences, and strengths in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem, and discussion of relevance to communication supports and services;
- 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;
- 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 and rationale as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services; as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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.		
Compliance rating:		
#	Indicator	Score
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.	22% 2/9
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	50% 3/6
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	25% 1/4
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A
Comments: a. The ISPs for Individual #38 and Individual #202 provided descriptions of how the individuals communicate and how staff should communicate with them. b. Individual #186, Individual #140, and Individual #215 did not need Communication Dictionaries. The individuals for whom evidence was found to show the IDT reviewed the Communication Dictionary, and the Communication Dictionary comprehensively addressed the individuals' nonverbal communication were: Individual #38, Individual #104, and Individual #202. c. The recommended communication interventions, strategies, and programs were included in the ISP of Individual #66.		

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.		
Compliance rating:		
#	Indicator	Score
1	The individual has skill acquisition plans.	100% 9/9
2	The SAPs are measurable.	83% 19/23
3	The individual's SAPs were based on assessment results.	91% 21/23
4	SAPs are practical, functional, and meaningful.	83% 19/23
5	Reliable and valid data are available that report/summarize the individual's status and progress.	22% 5/23
Comments: 1. All nine individuals had skill acquisition plans (SAP). The Monitoring Team chooses three SAPs from the current ISP for each individual for review. Individual #329 and Individual #38 had two SAPs and Individual #364 had one SAP, for a total of 23 for this review. 2-4. The majority of SAPs were measurable, based on assessment results, and were judged to be practical and meaningful.		

5. Only five SAPs were scored as having reliable data. The others did not meet criterion primarily because the data were incorrectly scored (e.g., Individual #296 delayed gratification SAP, Individual #100 dinning etiquette SAP, Individual #244 gain attention SAP, Individual #186 delayed gratification SAP) or data sheets were missing data (Individual #244 medication management SAP, Individual #100 medication information SAP).

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.		
Compliance rating:		
#	Indicator	Score
10	The individual has a current FSA, PSI, and vocational assessment.	67% 6/9
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	33% 3/9
12	These assessments included recommendations for skill acquisition.	44% 4/9
Comments: 10. An FSA or a PSI was missing for Individual #296, Individual #244 and Individual #153.		

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

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
20	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 5/5
21	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 5/5
22	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 5/5
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	80% 4/5
24	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	80% 4/5
25	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	80% 4/5
26	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	60% 3/5
27	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 5/5
28	The PBSP was complete.	N/A
29	The crisis intervention plan was complete.	100% 5/5
30	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 5/5
31	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 5/5
Comments: Five of the nine individuals reviewed had more than three restraints in a rolling 30 day period within the last six months (Individual #296, Individual #37, Individual #100, Individual #329, Individual #186). The		

ISPAs for all of those individuals indicated that the IDT met at sufficient intervals, discussed necessary topics, and generated appropriate actions to attempt to reduce future restraint. Individual #100's ISPAs did not indicate discussion (and action plans) for setting, antecedent, and consequent events for the dangerous behaviors that provoked restraint. In addition, Individual #37 and Individual #100's PBSPs were more than one year old.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.		
Compliance rating:		
#	Indicator	Score
1	If not receiving psychiatric services, a Reiss was conducted.	100% 1/1
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A

Comments:
1. For the 16 individuals reviewed by both Monitoring Teams, all, except Individual #66, were receiving psychiatric services. A Reiss screen was conducted for him and indicated that a referral for psychiatric services was not needed.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
8	The individual is making progress and/or maintaining stability.	0% 0/9
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	67% 6/9
11	Activity and/or revisions to treatment were implemented.	56% 5/9

Comments:
8-9. This outcome is concerned with the individual's general clinical status and stability. But, without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored as 0%. That being said, one of the individuals as reported to be doing well psychiatrically (Individual #153). This was based upon anecdotal information in the record, interviews with staff, observations of psychiatry clinics, and observations of the individual.

10. Despite the absence of measurable goals, there was evidence that the treatment team undertook interventions in an attempt to stabilize the individual if he or she was deteriorating for six of the individuals (Individual #329, Individual #244, Individual #100, Individual #37, Individual #296, Individual #153). The interventions were medication adjustments and/or changes.

11. If changes were recommended, they were implemented for all of these, except for Individual #329, who was supposed to, but did not, return to psychiatry clinic after one month following a medication change.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.		
Compliance rating:		
#	Indicator	Score
23	The derivation of the target behaviors was consistent in both the PBSP and the psychiatric documentation.	100% 9/9
24	The psychiatrist participated in the development of the PBSP.	0% 0/9
Comments: This outcome relates to the coordination of treatment between psychiatry and behavioral health services.		

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.		
Compliance rating:		
#	Indicator	Score
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	33% 1/3
26	Frequency was at least annual.	33% 1/3
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	33% 1/3
Comments: This outcome addresses the coordination between psychiatry and neurology. These indicators applied to three of the individuals (Individual #186, Individual #37, Individual #153). 25. Given Individual #329's psychiatry medications and her history of seizures, there should have been some collaboration. Individual #153's psychiatrist reviewed his neurologist's consultation notes, but no collaboration occurred.		

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.		
Compliance rating:		
#	Indicator	Score
33	Quarterly reviews were completed quarterly.	44% 4/9
34	Quarterly reviews contained required content.	0% 0/8
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 3/3
Comments: 33. There were gaps in the provision of quarterly reviews for four of the individuals. Individual #364 did not have any quarterly reviews. 34. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. The reviews were missing from two to nine components. The reviews for four (Individual #244, Individual #37, Individual #296, Individual #153) were missing two items: psychiatric diagnoses with description of symptoms that support the diagnoses, and whether the non-pharmacological interventions recommended by the psychiatrist and approved by the IDT were being implemented. Individual #364 was not included in this indicator. Other frequently missing components were whether data were presented and reviewed, and a description of plans for the future for treatment.		

35. Three psychiatric clinics observed by the Monitoring Team, however, contained all of the standard components (e.g., data, plans for medication and other treatment). Thus, it may be that the documentation of psychiatric clinic activities may need to be improved to better reflect the conduct and content of the clinics.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.		
Compliance rating:		
#	Indicator	Score
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	0% 0/9
Comments: 36. MOSES were completed every six months for six of the nine individuals, and reviewed by the prescriber for one of the individuals. DISCUS were completed every three months for six of the nine individuals, and reviewed by the prescriber for three of the individuals.		

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.		
Compliance rating:		
#	Indicator	Score
37	Emergency/urgent and follow-up/interim clinics were available if needed.	40% 2/5
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	40% 2/5
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 5/5
Comments: 37-39. These indicators were applied for Individual #186, Individual #38, Individual #329, Individual #37, and Individual #296. They occurred as needed and when requested for Individual #186 and Individual #38. For the others, not all requests for follow-up occurred (or were documented).		

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.		
Compliance rating:		
#	Indicator	Score
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A
Comments: 43. The facility did not utilize PEMA nor were psychiatric support plans used in lieu of PBSPs.		

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.		
Compliance rating:		
#	Indicator	Score
--	Is this individual receiving medications that meet the polypharmacy definition?	--
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	14% 1/7
45	There is a tapering plan, or rationale for why not.	14% 1/7
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	0% 0/7
Comments: The medication regimens of seven of the individuals met the definition of polypharmacy. 44. Individual #37's documentation provided empirical justification that met criterion for this indicator. 45. Individual #38's documentation provided a plan or rationale that met criterion for this indicator. 46. The facility was not holding a polypharmacy committee. This was discussed with facility management during the onsite review.		

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is making expected progress	33% 3/9
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A
8	The individual's progress note comments on the progress of the individual.	100% 9/9
9	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	71% 5/7
10	Activity and/or revisions to treatment were implemented.	40% 2/5
Comments: 6. Three individuals were rated as making progress (Individual #38, Individual #329, Individual #153). 8-9. All individuals had monthly PBSP progress notes. The progress notes documented the individual's progress and, generally, identified actions to be taken to address any lack of progress for all, except Individual #37 and Individual #244. 10. There was not documentation in the progress notes for Individual #100, Individual #364, and Individual #186, that showed that those actions were implemented.		

Outcome 4 – Quality of PBSP.		
Compliance rating:		
#	Indicator	Score
14	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	67% 6/9
Comments: 14. The criterion was met for all except Individual #37, Individual #100, and Individual #364.		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/9
18	There was a PBSP summary for float staff.	0% 0/9
Comments: 17. The data necessary to assess if direct support professionals responsible for implementing PBSPs were in fact trained on the plans were not available.		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	100% 9/9
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	67% 2/3
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%
Comments: 20. The graphs of all nine individuals were found to be simple, clear, and useful for analyzing individual target and replacement behavior. 22. It was encouraging to see that recommendations from peer review meetings resulted in completed actions. 23. San Angelo SSLC conducted weekly peer review meetings and monthly external peer review meetings. The Monitoring Team observed an internal peer review meeting and found it to include the necessary components of peer review. That is, the functional assessment and PBSP of an individual who was not progressing was presented, there was participation by the behavioral services staff, productive discussions, and generation of practical and useful recommendations for improving the individual's functional assessment and PBSP.		

Outcome 8 – Data collection		
Compliance rating:		
#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/9
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	0% 0/9
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 9/9
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 9/9
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9
Comments: 26-27. The data collection system for measuring undesired (target) behaviors was an ABC system for all individuals and all target behaviors. This system, which requires direct support professionals to record antecedents and consequences for each occurrence of each target behavior, is generally used for low frequency behaviors. For higher frequency target behaviors, however, it presents a substantial recording burden for DSPs and, therefore, often results in underreporting. Additionally, the occurrences of replacement/alternative behaviors were measured as SAP generalization data. Many of the SAP data sheets reviewed, however, appeared to confuse the occurrence of replacement/alternative behaviors with the training of the behavior. In general the data system did not appear to be sensitive to individual needs and did not adequately measure either undesired (target) or replacement/alternative behaviors. 28-30. San Angelo SSLC established a schedule of IOA, data collection reliability, and treatment integrity for each individual based on the each individual's level of behavioral risk. This was good to see, however, as discussed above, the IOA and data collection reliability measures did not occur at the frequency established and these goals were not achieved.		

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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	39% 7/18
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	39% 7/18
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	6% 1/18
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18
Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #38 – respiratory compromise, and other: anemia; Individual #140 – diabetes, and respiratory compromise; Individual #104 – diabetes, and gastrointestinal problems; Individual #71 – osteoporosis, and diabetes; Individual #66 – other: vitamin D deficiency, and seizures; Individual #76 – other: vitamin D deficiency, and other: hypothyroidism; Individual #202 – other: Chronic Hyponatremia,		

and other: metabolic syndrome; Individual #215 –respiratory compromise, and other: hyperthyroidism; and Individual #186 – seizures, and dental). The goals/objectives addressing individuals' selected chronic and/or at-risk diagnoses that were clinically relevant and achievable, and measurable and time-bound were those for: Individual #104 –gastrointestinal problems; Individual #71 – osteoporosis, and diabetes; Individual #66 – other: vitamin D deficiency, and seizures; and Individual #76 – other: vitamin D deficiency, and other: hypothyroidism. It should be noted that not all of these goals were memorialized in the ISP/IHCP. For example, the goals for Individual #76 – other: vitamin D deficiency, and other: hypothyroidism were included in the annual medical assessment, but not in the ISP/IHCP.

c. through e. Data was available in relation to Individual #66 – other: vitamin D deficiency, but the individual had not met the goal. The lab results for the Vitamin D were borderline with a result of 30. It was not clear if any adjustments were made to the medications regimen, because there were no IPN entries related to this value.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	100% 9/9
	ii. Colorectal cancer screening	60% 3/5
	iii. Breast cancer screening	100% 1/1
	iv. Vision screen	100% 9/9
	v. Hearing screen	100% 9/9
	vi. Osteoporosis	38% 3/8
	vii. Cervical cancer screening	25% 1/4

Comments: g.ii. The individuals that did not receive colorectal cancer screening were Individual #38 and Individual #104. For Individual #104, although the risk of doing a colonoscopy was documented as being too high, no evidence was found that a fecal occult blood test was completed. For Individual #38, the Medical Director indicated that colorectal cancer screening was not completed due to the fact that he had a Do Not Resuscitate (DNR) Order. As discussed below, sufficient justification was not found for the DNR Order.

g.v.i. The individuals that did not have timely preventative care related to osteoporosis were Individual #38, Individual #140, Individual #71, Individual #66, and Individual #76. Some of these individuals had chronic Vitamin D deficiencies, which placed them at risk for osteoporosis.

g.v.ii. The individuals for whom cervical cancer screening was not completed were Individual #202, Individual #215, Individual #186. For Individual #202, the IDT noted testing was suspended without

providing clinical justification. For Individual #215, there was documentation of human papilloma virus (HPV) testing, but not the required cervical cytology. For Individual #186, a gynecology consult, dated 4/8/13, did not document that cervical cytology was actually done in 2013, but noted it is repeated every three years. It documented that Neisseria and Chlamydia testing was done and pending. Additionally, the note documented that the individual needed annual pelvic examinations, but these were not documented in the records reviewed.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) have conditions justifying the orders.		
Compliance rating:		
#	Indicator	Score
a.	Individual with DNR has clinical condition that justifies the order and is consistent with the State Office Guidelines.	50% 1/2
Comments: The individuals the Monitoring Team reviewed that had DNR Orders were Individual #38 and Individual #66. For Individual #38, the DNR Order written on 1/13/15 stated: "remain DNR status (no CPR) resuscitation status III due to COPD." This contradicted documentation in the record that indicated the diagnosis was not firmly established. The lack of a clear diagnosis was acknowledged during interviews with the Medical and Facility Directors.		

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.		
Compliance rating:		
#	Indicator	Score
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.	10% 1/10
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.	0% 0/10
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.	83% 5/6
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
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.	100% 6/6
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 6/6
g.	Individual has a post-hospital ISPA that addresses supports to reduce risks and early recognition, as appropriate.	50% 1/2
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.	17% 1/6

Comments: a. For seven of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 10 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #140 for cellulitis on 3/23/15, and head trauma on 3/10/15; Individual #202 for respiratory illness on 1/28/15; Individual #215 for upper respiratory illness on 1/6/15, and asthma exacerbation on 11/26/14; Individual #76 for knee trauma on 2/24/15; Individual #71 for trauma/cellulitis on 12/15/15; Individual #186 for a scalp laceration on 4/23/15; Individual #38 for diarrhea on 2/24/15, and respiratory illness on 1/24/15. For Individual #140's cellulitis on 3/23/15, medical providers at San Angelo SSLC followed accepted clinical practice in assessing it. For the remaining individuals, issues varied, but some of the problems noted included: lack of timely assessment; lack of review of the history of the problem; lack of focused physical examinations, including documentation of all positive and negative results; missing review and summary of the most recent diagnostic tests; no definitive or differential diagnosis that clinically fit the corresponding evaluation or assessment; and insufficient plans for further evaluation, treatment, and monitoring.

The following provide some examples of specific issues noted:

- For Individual #140, nursing documented head trauma with some bleeding, superficial lacerations, bruising and facial swelling. Multiple IPNs noted a right "black eye." The PCP was notified and it was documented that "mild" neurological checks were ordered for 24 hours. A physician never evaluated the individual for these injuries.
- On 1/6/15, the PCP documented Individual #215 had cough for one week with phlegm. The diagnosis was upper respiratory infection. The plan was to check rapid flu test and provide symptomatic care. The results of the flu test were not documented. On 1/13/15, the PCP documented upper respiratory infection with cough, and the plan was symptomatic care. There was no further follow-up. Neither assessment included the required components of positive and negative findings. In fact, each assessment was limited to 10 to 20 words, which would appear inadequate for an individual with a history of acute respiratory failure, acute respiratory distress syndrome, and pulmonary artery hypertension and right heart failure.
- On 11/26/14, Individual #215 was diagnosed with asthma with exacerbation. No evidence was found that nationally acceptable clinical practice guidelines for management of asthma exacerbation were implemented.
- For Individual #76's knee trauma on 2/24/15, and Individual #71's trauma/cellulitis on 12/15/15, the PCPs did not document or order monitoring of the neurovascular status of the extremity that should be done for suspected trauma.
- For the following individuals' acute issues, no follow-up plans were documented: Individual #71 for trauma/cellulitis on 12/15/15; Individual #186 for a scalp laceration on 4/23/15; and Individual #38 for diarrhea on 2/24/15, and respiratory illness on 1/24/15.
- For Individual #38, on 2/24/15, the PCP noted in the IPN: "Diarrhea, profuse, on Levaquin/clindamycin; d/c [discontinue] both and check c. diff." This 10-word note was used to document a medical evaluation for an individual who was being assessed for a potentially serious infectious diarrhea. There was no documentation of a physical examination of the individual, vital signs, or any other signs or symptoms of disease. There was also no documentation of follow-up, or the results of the study. As noted above, there was no plan for follow-up.
- Individual #38 was seen on 1/27/15 and treated for congestive heart failure. The second PCP added oral steroids for wheezing on 2/5/15, and ordered a chest x-ray. A third PCP's diagnosis was a failing heart on 2/12/15. There was no additional follow-up for this acute condition, even though the diagnosis was not clear. The results of the chest x-ray were not documented. The AMA, completed on 4/1/15, acknowledged that the diagnosis of asthma/COPD was not clearly defined.

b. For none of the acute medical issues treated at the Facility was documentation found to show the PCP conducted necessary follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized.

c. Six acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including the following with dates of occurrence: Individual #140 on 11/3/14 for leg cellulitis; Individual

#202 on 2/1/15 for vaginal bleeding; Individual #104 on 4/22/15 for cellulitis, and on 1/31/15 for a scalp laceration; Individual #215 on 4/11/15 for bronchitis/asthma; and Individual #186 on 11/13/14 for an eye laceration. A provider conducted a timely evaluation prior to the transfer, or within one business day, if not feasible prior to the transfer, for all but Individual #104 on 1/31/15 for a scalp laceration.

d. Four of the acute illnesses reviewed occurred after hours, and, as a result, the PCP was not available to conduct assessments prior to the transfer. Of the ones for which this was applicable (i.e., Individual #140 on 11/3/14 for leg cellulitis, and Individual #186 on 11/13/14 for an eye laceration), they had a quality assessment documented in the IPNs.

e. It was positive that for the acute illnesses reviewed for which a hospitalization or ED visit was necessary individuals received timely treatment at the SSLC.

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

g. The IDT met and developed a post-hospital ISPA that addressed prevention and early recognition of signs and symptoms of illness for Individual #186 for an eye laceration that occurred on 11/13/14. An ISPA should have been held, but was not for Individual #202 in relation to her 2/1/15 vaginal bleeding. The records indicated that the IDT had discontinued all gynecological (GYN) examinations for this individual. There was no risk assessment documented, and the family history was unknown due to adoption status. Even though the records showed that some vaginal bleeding continued, there was no examination by any Facility physician. There was no documentation of pathology findings.

h. For the acute illnesses requiring ED visits and/or hospitalizations reviewed, the only one for which the PCP conducted necessary follow-up assessments was Individual #186's eye laceration on 11/13/14. Some examples of problems include:

- For Individual #202, on 2/1/15, nursing noted significant vaginal bleeding and notified the PCP who requested transfer to the ED. The individual returned to the Facility, and was seen by another PCP on 2/2/15. On 2/11/15, a third PCP documented a note disagreeing with the proposed management, but did not evaluate the individual. On 2/26/15, the PCP noted that the GYN consult was completed. The consult indicated that an endometrial biopsy was done and pathology results were pending. There were no further PCP entries related to this medical problem.
- For Individual #104's cellulitis, on 4/23/15, the PCP noted that records were reviewed, but individual was not at home, so was not seen. The ultrasound was negative for deep vein thrombosis, but a large lymph node was noted. On 4/24/15, another PCP examined the individual and commented that the diagnosis was cellulitis. There was no mention if the inguinal node was clinically apparent, and there was no further medical documentation in the records related to this acute medical problem.
- For Individual #215, on 4/12/15, the PCP noted the diagnosis was acute bronchitis or pure asthma exacerbation. Labs were to be checked in the morning, due to hypokalemia. However, there was no further documentation, which might be expected for someone who was transferred to the ED with distress and very low oxygen saturation rates. On 4/17/15, the individual was seen again for an unrelated episode of unresponsiveness. There was no documentation of lab findings. Again, there was no evidence that current management protocols for asthma were implemented, given the PCP documented that this episode may be "pure asthma exacerbation."

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.		
Compliance rating:		
#	Indicator	Score
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	81% 13/16

b.	PCP completes review within five business days, or sooner if clinically indicated.	81% 13/16
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	38% 6/16
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	79% 11/14
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #140 for ophthalmology on 10/24/14, and infectious disease on 12/15/14; Individual #202 for neurology on 11/20/14, and endocrinology on 5/1/15; Individual #104 for urology on 4/24/15, and ophthalmology on 12/24/14; Individual #215 for neurology on 1/16/15; Individual #76 for neurology on 3/6/15, and gastroenterology on 3/12/15; Individual #71 for neurology on 4/17/15, and neurology on 2/6/15; Individual #66 for neurology on 3/6/15; Individual #186 for neurology on 4/17/15/15, and ophthalmology on 11/14/14; and Individual #38 for hematology on 4/14/15, and rheumatology on 3/17/15.

a. and b. The consultations for which PCPs did not indicate agreement or disagreement with the recommendations were those for Individual #71 for neurology on 4/17/15, and neurology on 2/6/15; and Individual #66 for neurology on 3/6/15. Those that were not reviewed timely were for: Individual #140 for ophthalmology on 10/24/14, and infectious disease on 12/15/14; and Individual #202 for neurology on 11/20/14.

c. The consultations for which PCPs also wrote corresponding IPNs as State Office policy requires were those for: Individual #140 for ophthalmology on 10/24/14, and infectious disease on 12/15/14; Individual #104 for ophthalmology on 12/24/14; Individual #76 for gastroenterology on 3/12/15; Individual #186 for ophthalmology on 11/14/14; and Individual #38 for rheumatology on 3/17/15. For others, sometimes IPNs were present, but they did not include the necessary components.

d. For the consultations reviewed, when the PCP agreed with a recommendation, often evidence was available to show all the recommendations had been implemented. Those for whom this documentation was not found were for Individual #202 for neurology on 11/20/14, Individual #71 for neurology on 4/17/15, and Individual #66 for neurology on 3/6/15.

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

Compliance rating:

#	Indicator	Score
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	44% 8/18

Comments: For nine individuals, a total of 17 chronic and/or at-risk diagnoses were selected for review (i.e., Individual #38 – respiratory compromise, and other: anemia; Individual #140 – diabetes, and respiratory compromise; Individual #104 – diabetes, and gastrointestinal problems; Individual #71 – osteoporosis, and diabetes; Individual #66 – other: vitamin D deficiency, and seizures; Individual #76 – other: vitamin D deficiency, and other: hypothyroidism; Individual #202 – other: Chronic Hyponatremia, and other: metabolic syndrome; Individual #215 –respiratory compromise, and other: hyperthyroidism; and Individual #186 – seizures).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for: Individual #104 – gastrointestinal problems; Individual #215 – other: hyperthyroidism; Individual #76 – other: vitamin D deficiency, and other: hypothyroidism; Individual #71 – osteoporosis; Individual #66 –

other: vitamin D deficiency, and seizures; and Individual #186 – seizures. Some examples of problems noted for the remaining individuals' chronic or at-risk conditions included:

- For Individual #140, the Facility submitted lab work completed in March 2015, which was not consistent with the document request. More specifically, the Monitoring Team requested lab documentation for the past year, but the Facility provided only one month's lab documentation. However, it was noted that the Hemoglobin (Hb) A1c was 6.3. HbA1c values of 5.7-6.4 are consistent with increased risk of diabetes (i.e., pre-diabetes). Levels of 6.5 or greater are consistent with diabetes. A level of 6.3 is a significantly abnormal value, but the PCP did not address it in the IPNs. This morbidly obese individual, who is treated for hyperlipidemia and has sleep apnea, should be evaluated to determine if she has metabolic syndrome so that appropriate interventions can be implemented.
- For Individual #202, chronic hyponatremia has been noted since August 2014, and has not been acknowledged in the IPNs or evaluated. Sodium values as low as 127 have been noted in lab reports, but the PCP has never noted them in the IPNs. Multiple abnormal values have been documented. The AMA, dated 10/10/14, documented that this was a resolved problem.
- Individual #202 was diagnosed with metabolic syndrome per the active problem list. The IRRF stated the diagnosis was recently made. There was no physician documentation of the criteria used to make the diagnosis. There was also no plan of how the risks were to be mitigated.
- Individual #104 was rated at low risk for diabetes mellitus in the IRRF in March 2015. The PCP documented a HbA1c of 5.8 in the IPN on 2/19/15, but made no comment regarding this abnormal value.
- For Individual #38, the PCP noted that the accuracy of the diagnosis of asthma/COPD was questionable, stating: "this has not been clearly defined - we have scheduled a cardiology appointment." In addition, the medical management for this individual was not consistent with current guidelines for management of obstructive airway disease.
- Individual #38's records included a diagnosis of iron deficiency anemia, yet the appropriate workup for an adult male with such a diagnosis had not occurred. Additionally, the May 2015 MAR indicated that ferrous sulfate was administered daily for treatment of iron deficiency anemia. This was discussed with the Medical Director who indicated that the individual did not have iron deficiency and did not have a colonoscopy because of his DNR status.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.

Compliance rating:

#	Indicator	Score
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	33% 6/18

Comments: a. For the individuals' chronic conditions/at-risk diagnoses reviewed, evidence was found of thorough implementation of the interventions, including specific data to show their efficacy, for six of the conditions. This included the medical interventions for: Individual #66 – other: vitamin D deficiency, and seizures; Individual #186 – seizures; Individual #215 –respiratory compromise, and other: hyperthyroidism; and Individual #104 – gastrointestinal problems.

For the remaining individuals, as illustrated above with regard to Domain #2, ISPs/IHCPs infrequently set forth specific plans with detailed interventions and strategies. As a result, it was difficult to determine whether or not such plans were implemented thoroughly, and often, data were not available to determine the efficacy of the plans.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	100% 8/8
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	0% 0/5
Comments: a. For five of the nine individuals reviewed, a total of eight newly prescribed medications were identified. For seven of these, patient interventions were needed. These included two for Individual #71, two for Individual #140, one for Individual #66 (no intervention needed), two for Individual #251, and one for Individual #76. b. For Individual #71 (Bactrim DS on 12/15/14, and Norco on 12/15/14), Individual #140 (Bactrim DS on 5/11/15), and Individual #251 (KCl on 5/14/15, and Amoxicillin on 5/21/15), orders were written without a route. The pharmacy labels included the routes. It was unclear how the orders were clarified. Such documentation was not evident on the pharmacy copies of the physician orders. There were no submissions of interventions or order clarifications. The Clinical Pharmacist reported during interviews that documentation of interventions and order clarifications in WORx was inconsistent.		

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.		
Compliance rating:		
#	Indicator	Score
a.	QDRRs are completed quarterly by the pharmacist.	0% 0/18
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:	
	i. Laboratory results, including sub-therapeutic medication values;	0% 0/18
	ii. Benzodiazepine use;	0% 0/18
	iii. Medication polypharmacy;	0% 0/18
	iv. New generation antipsychotic use; and	0% 0/18
	v. Anticholinergic burden.	0% 0/18
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	0% 0/18
	ii. When the individual receives psychotropic medications, the psychiatrist	0%

	reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	0/18
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	0% 0/1

Comments: a. through c. The Monitoring Team requested the last two QDRRs for nine individuals (i.e., Individual #38, Individual #140, Individual #104, Individual #71, Individual #66, Individual #76, Individual #202, Individual #215, and Individual #186). None of the individuals had current QDRRs. In a number of instances, the most recent QDRRs were nine months to over a year old. As a result, up-to-date Pharmacy reviews of laboratory results, benzodiazepine use, medication polypharmacy, new generation anti-psychotic use, and anticholinergic burden were not available for prescribers' review.

d. For Individual #76, the outcome of the new order patient intervention was not clear. The PCP wanted to administer the pneumococcal vaccination a second time, because the individual had two episodes of pneumonia (not documented as pneumococcal). The Clinical Pharmacist noted that this was not indicated, but did not document the outcome of the intervention. The PCP provided no documentation in IPNs.

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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	17% 1/6
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	17% 1/6
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/6
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/6
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6

Comments: a. and b. The Monitoring Team reviewed six individuals with medium or high dental risk ratings (i.e., Individual #38, Individual #104, Individual #71, Individual #66, Individual #76, and Individual #202). The goal/objective that was clinically relevant and achievable, and measurable was the Skill Acquisition Plan for Individual #71.

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

Outcome 4 – Individuals maintain optimal oral hygiene.		
Compliance rating:		
#	Indicator	Score
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.	56% 5/9

b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	56% 5/9
c.	Individual has had x-rays, unless a justification has been provided for not conducting x-rays.	89% 8/9
d.	If the individual has need for restorative work, it is completed in a timely manner.	0% 0/5
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A

Comments: a. Individuals reviewed who did not receive prophylactic dental care at least twice a year were Individual #202, Individual #66 (who had none in 2014 or 2015), Individual #71, and Individual #38 (last prophylactic treatment documented in 2012).

b. The individuals for whom evidence was not found that Dental Department staff provided tooth-brushing instruction were Individual #38, Individual #66, Individual #215, and Individual #186.

The Annual Dental Summaries did not provide any specific directions to Facility staff regarding home oral care. The dentists did not document that oral hygiene instructions were provided. The dental hygienist noted in the treatment notes (dental progress notes) that instructions were given, but this was not consistently documented even for individuals who had a need for continued instruction.

c. For the individuals the Monitoring Team reviewed, it was good to see the Facility provided most of them with x-rays. The exception was Individual #38.

d. The individuals that needed restorative work, but did not receive it timely were Individual #38, Individual #140, Individual #71, Individual #76, and Individual #186.

Outcome 6 – Individuals receive timely, complete emergency dental care.		
Compliance rating:		
#	Indicator	Score
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 information the Facility provided in response to the pre-review document request, no individuals had experienced dental emergencies between October 2014 and April 2015.

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.		
Compliance rating:		
#	Indicator	Score
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	75% 3/4
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 3/3
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	67% 2/3
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	33% 1/3

Comments: a. through d. Individual #202 had a history of pneumonia and aspiration pneumonia, but the

assessment for suction tooth brushing was blank. The following individuals had suction tooth brushing included in their ISPs, and data showed it was completed: Individual #38, Individual #104, and Individual #66. Evidence of monitoring of the quality of the suction tooth brushing was not found for Individual #66. Information for suction tooth brushing was summarized/analyzed in the ISP monthly reviews for Individual #104.

Outcome 8 – Individuals who need them have dentures.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	0% 0/9
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A

Comments: a. The Annual Dental Examination form included a section related to dentures/partials. The dentist was to indicate if prosthetics were present or needed. The assessment was not completed for any of the individuals reviewed.

b. None of the individuals had recommendations for dentures.

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	44% 17/39
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.	32% 11/34
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	25% 8/32
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	18% 2/11
e.	The individual has an acute care plan that meets his/her needs.	0% 0/32
f.	The individual's acute care plan is implemented.	13% 4/32

Comments: The Monitoring Team reviewed 39 acute illnesses for seven individuals, including 10 for Individual #186; seven for Individual #38; four for Individual #140; four for Individual #104; six for Individual #71; four for Individual #202; and four for Individual #215.

a. The individuals' acute illnesses or occurrences for which nursing assessments were performed in accordance with nursing protocols or other relevant standards of care included those for Individual #186's laceration to left eye brow on 5/21/15, and head injury on 5/15/15; Individual #38's right lower lobe pneumonia on 12/15/14, Stage II decubitus on 11/18/14, dermatitis on 12/20/14, and Emergency Department (ED) visit/hospitalization on 5/28/15; Individual #104's ED visit on 4/22/15; Individual #71's injury/laceration/cellulitis to right elbow on 12/18/14, head injury on 12/13/14, pica on 11/24/14, pica on 12/2/14, and pica on 4/8/15; Individual #202's acute lower respiratory tract infection on 1/28/15, Urinary Tract Infection (UTI) on 2/1/15, ED visit on 2/9/15, and pneumonia on 5/3/15; and Individual #215's bronchitis/hypokalemia on 4/12/15. For the remaining individuals' acute illnesses/occurrences,

nursing assessments either were not conducted as soon as symptoms were observed, or they were not completed in alignment with nursing protocols. Some examples of problems included:

- Individual #186 was hospitalized from 12/4/15 to 12/23/15 for psychosis and suicidal intent. Prior to this hospitalization, nursing assessments did not correlate with a known acute mental illness. For example, nurses did not conduct observations/assessments of changes in behavior, eating habits, weight, etc., which would be associated with recognizing suicidal ideation, and, as applicable, instituting and monitoring suicidal precautions.
- On 4/8/15, Facility staff chemically restrained Individual #186. During the restraint, she experienced a change in vital signs from her baseline (i.e., baseline was 98/64, and during the restraint it dropped to 68/40). Nursing staff should have notified the PCP, but did not.

b. This did not apply to Individual #38's chemical restraints; or Individual #71's pica on 11/24/14, pica on 12/2/14, pica on 4/8/15, and pica on 4/15/15. Nursing staff timely notified the PCP in accordance with DADS SSLC nursing protocol entitled: "When contacting the PCP" of signs and symptoms related to Individual #38's right lower lobe pneumonia on 12/15/14, Stage II decubitus on 11/18/14, and ED visit/hospitalization on 5/28/15; Individual #104's chemical restraint on 5/28/15; Individual #71's injury/laceration/cellulitis to right elbow on 12/18/14, and head injury on 12/13/14; Individual #202's acute lower respiratory tract infection on 1/28/15, Urinary Tract Infection (UTI) on 2/1/15, ED visit on 2/9/15, and pneumonia on 5/3/15; and Individual #215's bronchitis/hypokalemia on 4/12/15. In other instances, symptoms were present that were not adequately assessed, and thus, not timely communicated to the PCP, or the physician was notified, but the information was not sufficient based on the event, the individual's current health status, and the risk.

c. This indicator was not applicable for Individual #186's "serious laceration to right lower lid;" Individual #104's ED visit on 1/8/15 for a scalp laceration, ED visit on 1/31/15 for a laceration/head injury, and 4/22/15 ED visit for cellulitis and to rule out a deep vein thrombosis; Individual #202's ED visit on 2/1/15 for a UTI, ED visit on 2/9/15 for moderate dysfunctional vaginal bleeding, and Individual #215's bronchitis/hypokalemia. For the remaining acute illnesses/occurrences, the completeness and consistency of the specific assessment criteria documented in the IPNs was problematic. The lack of consistent assessment criteria did not accurately reflect the individuals' on-going status regarding their acute health issue. In addition, nursing staff had administered multiple chemical restraints and/or pro re nata (PRN, or as needed) psychotropic medications to individuals reviewed (e.g., Individual #186, Individual #38, Individual #104, and Individual #215), but documentation was often not found as evidence that nurses monitored individuals' responses, including monitoring for adverse reactions and/or the efficacy of the medication.

d. The two acute illnesses/occurrences for which licensed nursing staff conducted complete pre- and post-hospitalization assessments were Individual #38's 5/28/15 ED visit and hospitalization, and Individual #202's pneumonia.

e. In a number of cases, an acute care plan should have been developed, but was not. For those that were developed, problems included, for example, plans not providing instructions regarding follow-up nursing assessments; not being in alignment with nursing protocols; not including specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; not defining the clinical indicators nursing would measure; and not identifying the frequency with which monitoring should occur.

f. Although acute care plans did not yet include all of the action steps necessary to meet individuals' needs, the Monitoring Team assessed whether or not nursing staff had implemented the action steps that were included. The acute care plans that nursing staff had implemented were those related to Individual #38's 5/28/15 ED visit/hospitalization, Individual #38's 11/18/14 Stage II decubitus, Individual #202's 1/28/15 acute lower respiratory tract infection, and Individual #215's bronchitis/hypokalemia.

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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	0% 0/18
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18
d.	Individual has made progress on his/her goal/objective.	0% 0/18
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #186 – fluid imbalance, and infections; Individual #38 – infections, and other - pain; Individual #140 – infections, and respiratory compromise; Individual #104 – UTIs, and gastrointestinal problems; Individual #71 – skin integrity, and gastrointestinal problems; Individual #66 – seizures, and constipation/bowel obstruction; Individual #76 – fluid imbalance, and constipation/bowel obstruction; Individual #202 – respiratory compromise, and infections; and Individual #215 – fluid imbalance, and respiratory compromise). None of the IHCPs included clinically relevant, achievable, and measurable goals/objectives.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.		
Compliance rating:		
#	Indicator	Score
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	N/A
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18

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

a. and c. For the individuals reviewed, evidence was not provided to support that individuals' IHCPs were implemented within 14 days of finalization or sooner. For individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs due to the lack of inclusion of regular assessments in alignment with nursing protocols. As a result, data were not available to show implementation of such assessments. In addition, at times, needed data sheets or flow sheets were not

found, or they did not contain the necessary data.

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	59% 10/17
b.	Medications that are not administered or the individual does not accept are explained.	0% 0/8
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 8/8
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	0% 0/9
e.	Individual's PNMP plan is followed during medication administration.	100% 8/8
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 8/8
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/9
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	100% 1/1
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/9
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1

Comments: While on site, the Monitoring Team conducted observations of medication administration for eight individuals, including: Individual #186, Individual #140, Individual #71, Individual #66, Individual #76, Individual #215, Individual #352, and Individual #119. The Monitoring Team also conducted record reviews for nine individuals, including Individual #186, Individual #38, Individual #140, Individual #104, Individual #66, Individual #76, Individual #202, Individual #215, and Individual #71.

a. During the onsite observations, individuals received their prescribed medications. Based on record reviews, Individual #66 and Individual #202 received their prescribed medications for the period reviewed. For the remaining seven individuals, there were unexplained Medication Administration Record (MAR) blanks. Because these blanks were not reconciled, it could not be determined whether or not the individuals received their medications, or if these were documentation errors. In addition, in some cases, MARs were not initialed for treatments (e.g., medicated cream or shampoo), but rather, notations were made that "staff does," or "DSP." Nurses are ultimately responsible for carrying out the physician orders. Even when nurses delegate such tasks, they maintain responsibility. In other words, the MARs should have been initialed to show that the treatments were carried out as ordered.

b. As noted above, explanations were not provided for MAR blanks. In addition, for individuals that refused medications, explanations and/or descriptions of attempts to administer the medications often were not

documented.

c. It was positive that during onsite observations, nurses followed the nine rights.

d. All individuals reviewed had received PRN, STAT, or one-time dose (e.g., chemical restraint) medications for which their responses were not documented.

Of significant concern, Individual #38's November MAR and subsequent MARs included as a routine medication order: "PRN-HS [at bedtime] IM [Intramuscular], if oral Olanzapine refused." The stated use of Olanzapine IM was for aggression. This raised a concern that the medication might be used as a PRN chemical restraint. Over the previous five years, the Monitoring Team identified the use of PRN psychotropic medication as an issue, and more recent Monitoring Team reports included findings that this issue was resolved. This order for Individual #38, therefore, was quite concerning. In addition, recently issued state regulations require the Facility to take certain steps before administering psychotropic medications against the will of an individual.

e. It was positive that for the individuals with PNMPs for whom the Monitoring Team conducted medication administration observations, nursing staff followed the PNMPs.

f. It was positive that during the Monitoring Team's onsite observations of medication administration, nurses used infection control procedures.

i. and j. For Individual #76, who experienced an ADR on 10/31/14, nursing staff reported to the PCP the reaction within one hour, for which there were corresponding nursing IPNs. Nursing IPNs included frequent observations that were in alignment with the individual's signs and symptoms.

k. As noted above, MAR blanks were found for all individuals reviewed, except for Individual #66. Although some were reported, such variances should be reconciled as quickly as possible to determine whether they are documentation errors or omissions of medications. For a number of medication variances, AVATAR forms were not submitted. In addition, medication variance forms often did not identify action steps to address the magnitude of the medication variances.

Of note, while on site, the Monitoring Team identified a number of potential medication variances. For example, in addition to unreported MAR blanks for many individuals reviewed:

- When the Monitoring Team went to observe Individual #38, it appeared the nurse had administered his medication early, and it was unclear how long the nurse(s) had engaged in this practice. A member of the Monitoring Team brought this to the attention of the Chief Nurse Executive, who sought clarification of the order from the PCP.
- The Monitoring Team identified a potential medication variance for Individual #104, who does not have a feeding tube, but who had a 3/23/15 order for medication to be administered by mouth or through a tube.
- For Individual #76, Haloperidol was ordered for administration every 28 days IM. The 2/27/15 Nursing IPN noted a recall of the medication Haloperidol, and physician contact to reschedule the dose. The Nursing IPN documented the medication was to arrive on 3/3/15. No further follow-up was found to address the issue. The MAR for February 2015 for Haloperidol was blank. The next dose was documented as administered on 3/28/15. No February physician orders were found to corroborate the issue with availability and/or order an alternative date for the administration of the medication.
- Individual #202 and Individual #215 take their medications by mouth, but had orders for at least one medication either by mouth or feeding tube.
- Individual #140 had a vaccine ordered, but no documentation was found to show it was administered, or that the order was acknowledged.

l. For Individual #140, the physician ordered a lab procedure to evaluate a value related to the medication

variance. The order was carried out.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	17% 1/6
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6
	iv. Individual has made progress on his/her goal/objective; and	0% 0/6
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/6
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	13% 2/15
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	67% 10/15
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/15
	iv. Individual has made progress on his/her goal/objective; and	0% 0/15
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/15

Comments: a.i. and a.ii. The Monitoring Team reviewed six areas of need for six individuals that met criteria for PNMT involvement, including: respiratory compromise for Individual #76, aspiration for Individual #66, aspiration for Individual #38, aspiration for Individual #104, falls for Individual #215, and falls for Individual #202. The PNMT did not review/assess or develop goals for Individual #76, Individual #66, Individual #104, and Individual #202, but should have. Individual #38 had a measurable goal, but not a clinically relevant/achievable goal.

b.i. and b.ii. The Monitoring Team reviewed 15 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: respiratory compromise, and choking for Individual #76; choking, and falls for Individual #186; fractures for Individual #66; skin integrity for Individual #38; circulatory, and falls for Individual #215; circulatory, and falls for Individual #140; falls for Individual #104; choking, and falls for Individual #202; and falls, and choking for Individual #71. The clinically relevant and achievable, and measurable goals were those for respiratory compromise for Individual #76, and circulatory for Individual #140. Measurable goals that were not clinically relevant were those for choking, and falls for Individual #186; fractures for Individual #66; circulatory for Individual #215; falls for Individual #140; falls for Individual #104; and choking, and falls for Individual #202.

a.iii. through a.v, and b.iii. through b.v. Overall, progress reports, including data and analysis of the data,

were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/8
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/1

Comments: a. As noted above, most IHCPs did not include all of the necessary action steps to meet individuals' needs. In addition, the timeframe and/or criteria for the completion of actions steps were often vague or just referenced the ISP date, and, as a result, there was no way to measure their completion.

b. Risks and/or changes in individuals' status that IDTs did not address timely included those for respiratory compromise, and choking for Individual #76; aspiration for Individual #66; falls for Individual #215; circulatory for Individual #140; falls for Individual #71; and aspiration, and falls for Individual #104. Some examples of issues included:

- For Individual #104, OT/PT reported a change in status related to falls during which he hit his head. He also experienced aspiration pneumonia, and the OT/PT reported ineffectiveness of supports 50% of the time. However, no evidence was found of PNMT review. The PCP identified an increase in falls on 2/26/15, but there was no evidence of an IDT meeting to discuss the issue of falls.
- In November 2014, Individual #140 had two ED visits related to cellulitis and lymphedema. However, no Habilitation Therapies representative was present at the ISPA meeting. In addition, there was no evidence of a PNMT RN review or OT/PT assessment.
- According to Individual #215's ISP dated 8/5/14, she had 24 falls in the last year due to medications, but no OT/PT assessment was requested at an established threshold or for the annual ISP meeting. Individual #215 had no PNMP. Since August, no ISPAs related to these issues were submitted. The IDT had established no thresholds for falls to trigger a team review.

c. Based on PNMT minutes, the PNMT discharged Individual #38. The Monitoring Team did not find evidence of an ISPA meeting showing review with the IDT of the PNMT recommendations for re-referral criteria.

Outcome 5 – Individuals' PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Compliance rating:		
#	Indicator	Score
a.	Individuals' PNMPs are implemented as written.	63% 27/43
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	67% 6/9

Comments: a. The Monitoring Team conducted 43 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during three out of nine observations (33%). Staff completed three of seven transfers (43%) correctly. Staff followed individuals' dining plans during 21

out of 27 mealtime observations (78%).

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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/5
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/5
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/5
d.	Individual has made progress on his/her OT/PT goal.	0% 0/5
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/5
Comments: a. and b. For four individuals reviewed, five goals/objectives and/or areas of need related to OT/PT services and supports were reviewed (i.e., Individual #76, Individual #38, Individual #215, and Individual #140- two). None of the individuals' goals/objectives were included in the ISP/IHCP, and were clinically relevant, achievable, and measurable. c. through e. As noted above, individuals generally did not have clinically relevant and measurable goals/objectives. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.		

Outcome 4 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 18/18
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	94% 17/18
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	78% 14/18
Comments: a. and b. The Monitoring Team conducted observations of 18 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment that was in working order. The exception to working condition was the wheelchair for Individual #383. c. Issues with proper fit were noted with regard to the wheelchairs for Individual #126, Individual #146, and Individual #202. Based on observations of each of these individuals, the outcome was that they were not positioned correctly in their wheelchairs. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly. Similarly, Individual #273's splint did not appear to provide proper 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.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6
5	If personal outcomes were met, the IDT updated or made new personal goals.	Cannot determine
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/1
7	Activity and/or revisions to supports were implemented.	Cannot determine

Comments: Once San Angelo SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.

4. Without measurable goals in place, it was not possible to determine if individuals were making progress on achieving their goals. For goals that were measurable, there were not sufficient data to determine whether or not progress was being made. For the one individual with measurable goals and consistent data (Individual #37), progress had not been made.

Outcome 9 – Implementation		
Compliance rating:		
#	Indicator	Score
10	Staff exhibited a level of competence to ensure implementation of the ISP.	33% 2/6
11	Action steps in the ISP were consistently implemented.	0% 0/6

Comments:
10. Overall, it was difficult to determine if staff exhibited a level of competence to ensure implementation of the ISP because plans were not being regularly and correctly implemented. When interviewed, however, most staff could describe basic supports and risks.

11. A review of data sheets, QIDP monthly reviews, and observations while onsite did not support that action plans were being implemented.

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.		
Compliance rating:		
#	Indicator	Score
6	The individual is progressing on his/her SAPS	33% 3/9

7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/1
8	If the individual was not making progress, actions were taken.	0% 0/6
9	Decisions to continue, discontinue, or modify SAPs were data based.	50% 6/12

Comments:
6. A determination of progress was able to made for only nine of the SAPs. The Monitoring Team was unable to assess if progress was being made on the others because data were not reviewed in QIDP report, available data sheets were incorrectly scored, and three or more months of data were not available to review for the others.

8-9. There was no evidence in the monthly QIDP reports that actions were taken to address the SAPs that were not progressing (e.g., retrain staff, modify the SAP, discontinue the SAP).

Outcome 4- All individuals have SAPs that contain the required components.		
Compliance rating:		
#	Indicator	Score
13	The individual's SAPs are complete.	23% 3/23

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although only three of the 23 SAPs reviewed were complete, the majority of SAPs contained most (but not all) of the necessary components. The most common missing element was clear documentation methodology that instructs DSPs in how to record the SAP. Given the relatively large percentage of SAP data sheets that had data incorrectly recorded, the facility needs to ensure that the SAP training sheets clearly explain how the data are to be recorded. Another component that was judged to be missing from many SAPs was specific training instructions.

Outcome 5- SAPs are implemented with integrity.		
Compliance rating:		
#	Indicator	Score
14	SAPs are implemented as written.	40% 2/5
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.	33% 3/9

Comments:
14. The Monitoring Team observed the implementation of five SAPs, including implementation of Individual #38's functional communication SAP twice, with two different DSPs. Only two of the five SAPs were implemented as written. The most common error was DSPs not knowing to train on all the steps of the task analysis. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity.

15. San Angelo SSLC conducted SAP integrity measures and established a minimum level of SAP integrity at 80% and a frequency of SAP integrity checks at one SAP per individual per year. Although these were not achieved, it was encouraging that the facility was consistently conducting SAP integrity. In order to improve the implementation of SAPs, it is suggested that the facility increase the frequency of SAP integrity to each individual's SAPs at least once every six months.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.		
Compliance rating:		
#	Indicator	Score
16	There is evidence that SAPs are reviewed monthly.	61% 14/23
17	SAP outcomes are graphed.	17% 4/23
Comments: 16. SAP outcomes were not regularly reviewed in the QIDP monthly reviews. For instance, Individual #153 had no monthly reviews, and others (e.g., Individual #329) had reviews that included SAPs, but no SAP data were presented.		

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.		
Compliance rating:		
#	Indicator	Score
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9
21	The facility's goal levels of engagement achieved in the individual's day and treatment sites achieved.	56% 5/9
Comments: 18. The Monitoring Team directly observed all nine individuals a number of times in various settings on campus during the onsite week. Individual #244 and Individual #37 were rated as regularly engaged in activities. A focus on providing opportunities, and encouraging individuals, to be engaged in activities remains important for San Angelo SSLC. This is especially relevant given the population at the facility, at homes such as 509 where, in the late afternoon, there was not much going on, a condition that sets the occasion for problem behaviors to occur. We realize this is an extremely challenging problem and that the facility has been working on this for quite some time.		

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.		
Compliance rating:		
#	Indicator	Score
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9
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. There was evidence that most of individual's participated in community outings, however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved. 23. It was encouraging to see that the majority of individual's did conduct SAPs in the community, however, there were no established goals for SAP training in the community. A goal for the frequency of		

SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal is achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	0% 0/2
Comments: 25. The facility maintained an excellent working relationship with the local independent school district. A number of students graduated this year. Regular meetings were being held. ISD staff attend ISP meetings, one of which was observed by the Monitoring Team (for Individual #296). During this ISP meeting, there was good discussion of whether the individual should participate in academic activities over the summer break. Individual #329 and Individual #296 were included in this outcome. The integration of these students' IEP and their IDT was not found in either of their ISPs, monthly QIDP reports, or ISPAs. Individual #296's draft ISP, however, included a lot of information about her school program.		

Dental

Outcome 2 – Individuals with a history of refusals cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	100% 1/1
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1
Comments: Of the nine individuals the Monitoring Team reviewed, Individual #71 had documented refusals. He had a clinically relevant, achievable goal to increase his compliance with going to the clinic for tooth brushing. However, the goal was not measurable, and data based on its implementation was not analyzed in the integrated ISP reviews.		

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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/7

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	14% 1/7
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/7
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/7
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/7

Comments: a. and b. Seven of the nine individuals reviewed had seven communication-related goals/objectives and/or areas of need (i.e., Individual #76, Individual #186, Individual #66, Individual #38, Individual #104, Individual #202, and Individual #71). None of the individuals had goals/objectives included in the ISP/ISPA that were clinically relevant and achievable. The one that was measurable, but not clinically relevant and/or achievable was the one for Individual #186.

c. through e. Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As noted above, individuals generally did not have clinically relevant and measurable goals/objectives. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Outcome 4 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.

Compliance rating:

#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	75% 3/4
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	50% 2/4
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.	67% 4/6

Comments: a. The Monitoring Team observed four individuals with AAC/EC systems or devices, including: Individual #38, Individual #211, Individual #137, and Individual #253. The AAC/EC device that was not present was the one for Individual #38. His device was found on his dresser in his room covered with other items.

b. Overall, during visits to individuals' homes and day/work sites, the Monitoring Team saw limited to no use of communication devices. This was concerning. For the formal observations, the individuals that were not using their devices, and staff were not encouraging them to use their devices were Individual #38 during multiple observations, and Individual #137. Some positive examples of the use of communication devices were:

- Individual #211 readily used her communication wallet when a member of the Monitoring Team approached her; and
- Individual #253 used a single message switch to ask for his daily newspaper at the switchboard. The switchboard operator said "hi," but did not otherwise interact with him until he pressed the button to request the newspaper, then she went to get it for him. The next step will be for him to pick up multiple papers and deliver them to others who have paid for papers.

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

Domain #6: Individuals in the Target Population will receive services in the most integrated setting, with the frequency, intensity, and duration necessary to meet their appropriately identified needs, consistent with their informed choice.

To repeat from the "Background" section at the beginning of this report, the outcomes and indicators for monitoring each SSLC's quality assurance program and some aspects of the facility's most integrated setting practices were not finalized. This was due to the State and DOJ's continued discussions regarding the most integrated setting practices, and the State's efforts to completely revise its quality assurance system. Therefore, outcomes, indicators, and scores for Domains #5 and #6 were not completed for this review.

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, 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 8/1/14, with date of admission;
- Individuals placed in the community since 8/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 8/1/14;
- List of individuals with an ISP meeting, or a pre-ISP 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 over the past six months;
    - Individuals discharged by the PNMT over the last six months;
    - In alphabetical order: 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 during the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - During the past six months, individuals who have had a choking incident, date of occurrence, what they choked on, and identification of individuals requiring abdominal thrust;
    - During 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;
    - During 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;
    - During the past six months, individuals who have experienced a fracture;
    - During the past six months, individuals who have had a fecal impaction;
    - In alphabetical order: Individuals with fair or poor oral hygiene;
    - List of individuals receiving direct OT and/or PT services and focus of intervention;
    - In alphabetical order: 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
    - In alphabetical order: List of individuals with severe communication deficits;

    - List of individuals receiving direct speech services, including focus of intervention;
    - In alphabetical order: List of individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior;
    - In alphabetical order: List of individuals with PBSPs and replacement behaviors related to communication.
    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is required;
    - Individuals that have refused dental services over the past six months;
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - Individuals with dental emergencies over the past six months; and
    - List of individuals with Do Not Resuscitate Orders.
- Crisis intervention restraint, since 5/1/14.
- Medical restraint, since 6/1/14.
- Protective devices, since 6/1/14.
- Since 6/1/14, a list of any injuries to individuals that occurred during restraint.
- A list of all DFPS cases since 6/1/14.
- A list of all serious injuries since 6/1/14.
- Since 6/1/14, a list of all injuries from individual-to-individual aggression.
- A list of all "serious incidents" (other than ANE and serious injuries) since 6/1/14.
- A list of the Non-serious Injury Investigations (NSIs) 6/1/14.
- Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
- Were reviewed by external peer review
- Were reviewed by internal peer review
- Were under age 22 as of 9/1/14
- For individuals receiving psychiatry services, information about 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
- 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
- Last two quarterly trend reports regarding allegations, incidents, and injuries with (a) any related action plans developed to address trends and (b) any documentation related to implementation and review of efficacy of the plans.
- Log of employees reassigned due to allegations of abuse and neglect in the past six months.
- The DADS report that lists staff (alpha) 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.
- QAQI Council for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- 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
- 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
- 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
- Documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months of Integrated Progress Notes for Nursing, 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.
- 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
- Last three months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last two 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
- Previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary
- For last six months, dental progress notes and IPNs related to dental care

- WORx Patient Interventions for the last six months
- IPNs related to pharmacy recommendations
- 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
- 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
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- 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
- ISPAs related to communication
- 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

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
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- All annual ISP assessments
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment and FSA Summary
- PSI
- All QIDP Monthly Reviews
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.

- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation, including NSIs.
- 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.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
BPH	Benign Prostatic Hyperplasia
CHF	Congestive Heart Failure
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CPE	Comprehensive Psychiatric Evaluation
CT	Computed Tomography
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
FSA	Functional Skills Assessment
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin
HDL	High-density Lipoprotein
HRC	Human Rights Committee
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
LTBI	Latent Tuberculosis Infection
MAR	Medication Administration Record
ml	milliliters
MRSA	Methicillin-resistant Staphylococcus aureus
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEMA	Psychiatric Emergency Medication Administration
PET	Positron Emission Tomography
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
RN	Registered Nurse
SAP	Skill Acquisition Program
TIVA	Total Intravenous Anesthesia