United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

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Background

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

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

In mid-2014, the parties determined that the facilities were more likely to make progress and achieve substantial compliance with the Settlement Agreement if monitoring focused upon a small number of individuals, the way those individuals received supports and services, and the types of outcomes that those individuals experienced. To that end, the Monitors and their team members developed sets of outcomes, indicators, tools, and procedures.

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

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

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of

the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement.

Organization of Report

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

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

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at San Antonio SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

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

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Thirteen of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This included four outcomes: outcomes #4, #5, and #6 for Restraint, and Outcome #8 for Abuse, Neglect, and Incident Management.

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

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

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

<u>Restraint</u>
The overall use of crisis intervention restraint was higher than during the last review; and the census-adjusted rate was in the middle compared to the other 12 facilities. Individuals who were restrained, however, received that restraint in a safe manner that followed state policy and generally accepted professional standards of care. This included the monitoring of individuals during and after restraint, completing documentation properly, and conducting thorough reviews post-restraint. The exception was proper involvement of psychiatry in crisis intervention chemical restraint implementation and review and nursing. In describing individuals' mental status as part of restraint documentation, nursing staff need to provide more detailed descriptions, including specific comparisons to the individual's baseline. In addition, Medication Administration Records, as well as IPNs need to document the administration of chemical restraints.

Staff who were responsible for providing restraint were knowledgeable regarding approved restraint practices. An area for focus is making sure that each individual's team was determining who should not be physically restrained and make sure that proper documentation occurred in the IRRF section of the ISP as well as in any relevant ISPA

Abuse, Neglect, and Incident Management
There was improvement, or maintenance of relatively high performance, in many areas, including reporting of allegations; education and knowledge of staff, individuals, and families; implementing protections after allegations; the content of investigations; and audits of serious and non-serious injuries. Five indicators were moved to the category of requiring less oversight.

Protections were in place prior to the incident occurring for all but one incident reviewed by the Monitoring Team. Examples included implementation of PBSPs and revisions to PBSPs when needed. Ensuring that all staff sign the annual duty to report forms needs to be improved. There are two other areas for focus. One is ensuring that all recommendations from investigations are implemented (or provide a rationale as to why not). The other is regarding the facility's QA system in this area. Current month data were available, but there was no longitudinal review or analysis.

Other
Overall, pretreatment chemical restraint practices needed more focus in order to meet the outcomes and indicators evaluated by the Monitoring Teams.

In the six months prior to the review, San Antonio SSLC completed seven Drug Utilization Evaluations (DUEs). Four of the DUEs provided very good assessments of drug utilization for clinically relevant topics. Other evaluations did not meet the criteria for a proper DUE. The Center needs to focus on completing DUEs that are consistently clinically significant. In addition, recommendations should be generated, as appropriate, and followed through to closure.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: Some aspects of the use of crisis intervention restraint at San Antonio SSLC were at low levels of occurrence. Others aspects were occurring at an ascending rate or had not shown any decrease. The director of behavioral health services was well aware of the data discussed in this outcome. Moreover, she regularly presented the same types of data to the facility's Quality Assurance and Quality Improvement Council. Ongoing attention from the director, QAQI Council, and restraint review committee remains warranted. The score for indicator 1 remained the same as the last review; indicator 2 showed some increase. Both of the indicators in this outcome will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
1	There has been an overall decrease in, or ongoing low usage of,	67%	This is a facility indicator.								

	restraints at the facility.	8/12									
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	56% 5/9	0/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (October 2015 through June 2016) were reviewed. The overall use of crisis intervention restraint was higher than during the last review and did not show a decreasing trend during this nine-month period, ranging from 12 to 27 occurrences per month. San Antonio SSLC's census-adjusted rate was in the middle compared to the other 12 facilities. The occurrences of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint because most restraints were physical crisis intervention restraints. The average duration of a physical restraint showed a slightly ascending trend, at an average of about five minutes per restraint. This was also about middle compared to the other facilities. The number of crisis intervention chemical restraints was low and, moreover, the percentage of crisis intervention restraints that were chemical crisis intervention restraints decreased by more than half since the last review. That being said, some instances of crisis intervention chemical restraint were classified as psychiatric emergency medication administration (PEMA). In late April 2016, the facility practice changed to categorize all instances as crisis intervention chemical restraint and, thereby, provide the associated protections to individuals. There were no occurrences of crisis intervention mechanical restraints.

The number of injuries that occurred during or due to restraint was low or at zero for each month. Any injuries that did occur were deemed to be non-serious. The number of different individuals who received crisis intervention restraint, however, was not decreasing. It ranged from five to 12 per month. The director of behavioral health services reported that most individuals in this category had received a single crisis intervention restraint. The number of individuals who had protective mechanical restraint for self-injurious behavior fluctuated each month, but showed a decreasing trend over the second half of the nine-month period. The director of behavioral health services reported that the data in the graph were incorrect and that the number remained stable across the period at five. Three of these five were abdominal binders, and one was a wristlet for an individual who was newly admitted with the wristlet as part of his program.

The use of chemical or non-chemical restraints for dental procedures was at low or zero occurrences, respectively. The use of non-chemical restraint for medical procedures was also at zero occurrences. The use of chemical restraint for medical procedures showed a slightly ascending trend, but overall was at a low level.

Thus, state and facility data showed low usage and/or decreases in eight of these 12 facility-wide measures (i.e., use of crisis intervention chemical and mechanical restraint, the number of injuries that occurred during restraint, the number of individuals with protective mechanical restraint for self-injurious behavior, and the use of chemical and non-chemical restraints for medical and dental procedures).

2. Seven of the individuals reviewed by the Monitoring Team were subject to restraint. Five received crisis intervention physical restraints (Individual #109, Individual #290, Individual #214, Individual #84, Individual #187), and three received crisis intervention chemical restraint (Individual #109, Individual #95, Individual #199). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for three (Individual #95, Individual #214, Individual #187). The other two individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.												
Summary: Overall, San Antonio SSLC implemented restraint according to most of the criteria in this outcome. For instance, four of the indicators have had high scores for multiple reviews (3, 4, 7, and 8). These four indicators will move to the category of requiring less oversight. The other indicators require continued focus, especially indicator 9, and will remain in active monitoring. Correction of the problems regarding restraint contraindications will also likely result in higher scores on the other indicators at the next review.			Individuals:									
#	Indicator	Overall Score	109	290	95	214	84	199	187		
3	There was no evidence of prone restraint used.	100% 10/10	2/2	1/1	1/1	2/2	2/2	1/1	1/1		
4	The restraint was a method approved in facility policy.	100% 10/10	2/2	1/1	1/1	2/2	2/2	1/1	1/1		
5	The individual posed an immediate and serious risk of harm to him/herself or others.	90% 9/10	2/2	1/1	1/1	2/2	2/2	1/1	0/1		
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 7/7	1/1	1/1	N/A	2/2	2/2	N/A	1/1		
7	There was no injury to the individual as a result of implementation of the restraint.	100% 10/10	2/2	1/1	1/1	2/2	2/2	1/1	1/1		
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 10/10	2/2	1/1	1/1	2/2	2/2	1/1	1/1		
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/6	0/2	0/1	Not rated	Not rated	0/2	0/1	Not rated		
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 8/8	2/2	1/1	N/A	2/2	2/2	N/A	1/1		
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	60% 6/10	2/2	1/1	0/1	2/2	0/2	0/1	1/1		

Comments:
The Monitoring Team chose to review 10 restraint incidents that occurred for seven different individuals (Individual #109, Individual #290, Individual #95, Individual #214, Individual #84, Individual #199, Individual #187). Of these, seven were crisis intervention physical restraints, and three were crisis intervention chemical restraints. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC

utilized restraint and the SSLC's efforts to reduce the use of restraint.

5. The restraint checklist for Individual #187 3/23/16 stated that the restraint occurred because the individual hit the staff. More detail was needed in order to determine that the individual posed an immediate and serious risk of harm.

9. Because criterion for indicator #2 was met for three of the seven individuals, this indicator was not scored for them. For the other four, criteria for this indicator were not met because of the absence of psychiatric comprehensive evaluations and psychiatric supports not being integrated into PBSPs and other non-pharmacological strategies (Individual #109, Individual #290, Individual #84). For Individual #199, in addition to the problems with the integration of psychiatric supports, the ruling out of medical factors in self-injury were not evident, and his goals were not sufficient to support his active engagement in activities that would serve as an alternative to restraint.

10. There was no evidence or documentation of the consideration of physical restraint or any other less restrictive restraint prior to the use of chemical restraint for Individual #95 and Individual #199. This led to much discussion while onsite between the Monitoring Team and the director of behavioral health services. She explained rationales for both individuals that were reasonable (e.g., Individual #95's chemical restraint happened in the middle of the night and the conditions at the time made it unsafe to do a physical restraint, Individual #199 had a feeding tube and physical restraint was not allowed). The director of behavioral health services said that she was going to get to work immediately to make sure that each individual's team was determining who should not be physically restrained and make sure that proper documentation occurred in the IRRF section of the ISP as well as in any relevant ISPA. She also agreed that a crisis intervention plan for Individual #95 could help guide staff and would be developed. The absence of documentation and/or team review resulted in these two restraints not meeting criterion for this indicator.

11. As noted immediately above, the facility was routinely using crisis intervention chemical restraint for Individual #95 and Individual #199 without sufficient documentation to show that a less restrictive restraint had been considered prior to the admission of a chemical restraint. Furthermore, there was no documentation that the IDT had considered the risk associated with restraint for either individual. In addition to these two individuals, the restraint consideration section of the ISP IRRFs was not correctly completed for Individual #84.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: Staff correctly answered questions about the usage of crisis intervention restraint. This indicator was scored at 100% for this review and the two previous reviews and, therefore, this indicator will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	109	290	95	214	84	199	187		
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 4/4	Not rated	1/1	1/1	Not rated	1/1	1/1	Not rated		

Comments:

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: San Antonio SSLC showed good performance on this indicator at this review. With sustained performance, it is likely that these indicators will move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	109	290	95	214	84	199	187		
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 10/10	2/2	1/1	1/1	2/2	2/2	1/1	1/1		
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Comments:											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: As part of restraint monitoring, nursing staff need to improve their documentation of individuals' mental status. Nurses need to provide more detailed descriptions, including specific comparisons to the individual's baseline. In addition, Medication Administration Records, as well as IPNs need to document the administration of chemical restraints. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	109	290	95	214	84	199	187		
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	10% 1/10	0/2	0/1	0/1	0/2	0/2	1/1	0/1		
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	60% 6/10	1/2	0/1	1/1	2/2	1/2	0/1	1/1		
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/4	0/1	0/1	N/A	N/A	0/1	0/1	N/A		
Comments: The crisis intervention restraints reviewed included those for: Individual #109 on 5/26/16 at 4:40 p.m. (chemical), and on 6/23/16 at 11:19 a.m.; Individual #290 on 2/15/16 at 11:15 a.m.; Individual #95 on 5/15/16 at 3:30 a.m. (chemical); Individual #214 on 3/17/16 at 1:08 p.m., and 6/17/16 at 8:36 a.m.; Individual #84 on 1/6/16 at 6:15 p.m., and 4/11/16 at 3:42 p.m.; Individual #199											

on 5/29/16 at 1:35 p.m. (chemical); and Individual #187 on 3/23/16 at 7:55 p.m.

a. For the 10 restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint, which was good to see.

For nine of the 10 restraints, nursing staff properly monitored and documented vital signs. The exception was for Individual #109's restraint on 6/23/16 at 11:19 a.m., for which pulse oximetry readings were omitted.

Nursing staff documented and monitored mental status for Individual #199 on 5/29/16 at 1:35 p.m. In other instances, no mental status assessment was documented or sufficient description was not provided of the individual's mental status (e.g., "awake and alert").

b. and c. For Individual #109 on 5/26/16 at 4:40 p.m. (chemical), the Face-to-Face Debriefing Form indicated an injury report was completed, but no injury report was found. In addition, no Medication Administration Record (MAR) was provided to verify the administration of the chemical restraint, nor was a nursing Integrated Progress Note (IPN) provided to corroborate the administration of the medication.

For Individual #290 on 2/15/16 at 11:15 a.m., the Face-to-Face Debriefing Form indicated an injury report was completed, but no injury report was found.

For Individual #84 on 1/6/16 at 6:15 p.m., the Face-to-Face Debriefing Form indicated an injury report was completed, but no injury report was found. A Nursing IPN, dated 1/6/16 (with the incorrect time noted as 616, rather than 1616 hours, or 4:16 p.m.) indicated: "consumer assessed noted 1cm area of redness to middle forehead, cleansed with h20 and soap, neuro checks started." However, the next entry was dated 1/7/16 at 10:45 a.m. The initial nursing assessment indicated a need to implement the mild head injury protocol, but it was not followed.

For Individual #199 on 5/29/16 at 1:35 p.m. (chemical), the Face-to-Face Debriefing Form indicated an injury report was completed, but no injury report was found. In addition, no entry on the MAR verified the administration of the chemical restraint, nor was a nursing IPN provided to corroborate the administration of the medication.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
Summary: Facility performance maintained over the course of this review and the past two reviews at 100%. Given this excellent and sustained history of documentation, this indictor will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	109	290	95	214	84	199	187		
15	Restraint was documented in compliance with Appendix A.	100% 10/10	2/2	1/1	1/1	2/2	2/2	1/1	1/1		
Comments:											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: Facility performance maintained over the course of this review and the past two reviews at 100% for both of these indicators. Given this excellent and sustained history of crisis restraint review, these indictors will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	109	290	95	214	84	199	187		
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 10/10	2/2	1/1	1/1	2/2	2/2	1/1	1/1		
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 10/10	2/2	1/1	1/1	2/2	2/2	1/1	1/1		
	Comments:										

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner.											
Summary: For this review and the last review, these indicators, regarding psychiatrist involvement in chemical crisis intervention restraint, did not meet criteria. In the February 2015 review, indicators 47 and 49 scored at 100%. Likely, the turnover in psychiatry staff at the facility contributed to there being challenges in completing these protection from harm aspects of restraint management. All three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	95	199						
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/3	0/1	0/1	0/1						
48	Multiple medications were not used during chemical restraint.	33% 1/3	0/1	0/1	1/1						
49	Psychiatry follow-up occurred following chemical restraint.	0% 0/3	0/1	0/1	0/1						
	Comments: 47-49. These indicators applied to chemical restraints for Individual #199, Individual #95, and Individual #109. In all three cases, the psychiatric review via the form Administration of Chemical Restraint: Consult and Review occurred almost two months after the restraint, and there was no psychiatric follow-up clinic documented.										

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Overall, good progress was made in addressing the requirements of this outcome and its indicator. As noted in the comments below, completed annual signed forms for staff to acknowledge their reporting requirements were not available for some staff. The facility should ensure that this is corrected for all staff at the facility. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	187	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	50% 5/10	1/1	1/1	1/1	0/1	2/2	0/1	0/2	0/1	

Comments:
The Monitoring Team reviewed 10 investigations that occurred for eight individuals. Of these 10 investigations, seven were DFPS investigations of abuse-neglect allegations (zero confirmed, four unconfirmed, one inconclusive, two administrative referral back to the facility). The other three were for facility investigations of a serious discovered injury, and unauthorized departures from the facility and from the individual's mother's home during a visit. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #109, UIR 2648, DFPS 44382289, inconclusive neglect allegation, 6/5/16
- Individual #290, UIR 2442, DFPS 44215989, administrative referral of neglect allegation, 2/5/16
- Individual #95, UIR 2611, DFPS 44355697, administrative referral of physical abuse II allegation, 5/18/16
- Individual #262, UIR 16-019, serious discovered injury, 12/20/15
- Individual #41, UIR 2451, DFPS 44206840, unconfirmed physical abuse II allegation, 1/30/16
- Individual #41, UIR 16-050, unauthorized departure, 5/1/16
- Individual #214, UIR 2571, DFPS 44305152, unconfirmed physical abuse II allegation, 4/14/16
- Individual #84, UIR 2558, DFPS 44304089, unconfirmed physical abuse II allegation, 4/13/16
- Individual #84, UIR 16-067, unauthorized departure, 6/18/16
- Individual #187, UIR 2404, DFPS 44197632, unconfirmed neglect allegation, 1/23/16

1. For all 10 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

Five of the investigations did not meet criterion for this indicator because annual signed duty to report forms were not provided for all staff members. For four of these five investigations, this was the sole reason for the failure to meet criterion (Individual #262 UIR 16-019, Individual #214 UIR 2571, Individual #84 UIR 2558, Individual #187 UIR 2404). The facility was provided with the details about this (i.e., the names and dates of the staff members), but no response was provided to the Monitoring Team. For the other investigation that did not meet criterion (Individual #84 UIR 16-067), important replacement behavior supports were not being implemented. Overall, for the other individuals, plans were implemented and revisions were made by behavioral health specialists, an improvement from the previous review.

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

Summary: Most incidents were reported correctly and, moreover, there was improvement since the last onsite review. The facility should ensure that any inconsistencies in reporting information is cleared up and clarified in the UIR. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	290	95	262	41	214	84	187	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	80% 8/10	1/1	1/1	1/1	1/1	1/2	1/1	2/2	0/1	

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

Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #41 UIR 2451: The UIR indicated that at 10:10 am, Individual #41 reported to someone at the facility that he was pushed. This someone reported the incident to DFPS at 10:26 am but did not simultaneously report it to the facility director/designee. The facility director/designee was notified at 11:20 am, after the facility was notified of the allegation by DFPS.
- Individual #187 UIR 2404: The UIR, on page 7, noted that at 1:45 pm, after video review, staff made a determination to call in alleged neglect. The DFPS report showed that it did not receive the report until 8:23 pm. The UIR showed facility director/designee notification at 1:55 pm. There was no information in the UIR to explain or reconcile these times.

After reviewing the circumstances associates with the unauthorized departure of Individual #109, the facility determined that the incident should be called in as an allegation of possible neglect (Individual #109 UIR 2648). This was a good practice to see and was an example of the overall improved incident management practices at San Antonio SSLC.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.											
Summary: San Antonio SSLC maintained good performance across this review and the last two reviews with 100% scores on all three indicators. Therefore, indicators 4 and 5 will move to the category of requiring less oversight. Indicator 3 will remain in active oversight, in part, due to the need for improvement in reporting.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	187	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 3/3	Not rated	Not rated	Not rated	1/1	Not rated	1/1	1/1	Not rated	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 10/10	1/1	1/1	1/1	1/1	2/2	1/1	2/2	1/1	

Comments:
3. Because indicator #1 was met for five of the individuals, this indicator was not scored for them. The indicator was scored for the other three individuals and criteria were met.

4. Criteria for all four aspects of indicator 4 were met.

5. There were no occurrences of expressions of concerns of retaliation.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
Summary: San Antonio SSLC met criterion for this indicator for all but one of the investigations. Due to the importance of reassignment of alleged perpetrators, this indicator will remain in active monitoring, but with sustained performance, as was demonstrated during the last two reviews, which were both at 100%, this indicator is likely to move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	187	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	90% 9/10	1/1	1/1	1/1	1/1	2/2	1/1	1/2	1/1	

Comments:
6. For Individual #84 UIR 2558, the UIR referred to an IDT meeting where the alleged perpetrator was to be reassigned, but the UIR did

not include the customary and typical entry noting that the alleged perpetrator was, in fact, reassigned.

Outcome 5– Staff cooperate with investigations.											
Summary: San Antonio SSLC met criterion for this indicator for all but one of the investigations. Due to the importance of staff cooperation and participation in investigations, this indicator will remain in active monitoring, but with sustained performance, as was demonstrated during the last two reviews, which were both at 100%, this indicator is likely to move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	187	
7	Facility staff cooperated with the investigation.	90% 9/10	0/1	1/1	1/1	1/1	2/2	1/1	2/2	1/1	
Comments: 7. For Individual #109 UIR 2648, an extension for investigation completion stated that the reason for the extension was that witnesses had not been available for interviews. The UIR did not make it clear whether the cause of this was DFPS not initiating interviews soon enough, if the facility could not make the staff available, or for some other reason. The UIR should have narratively addressed this. When interviews start late, there is potential for testimonial evidence being compromised.											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: The facility showed improved performance in indicators 8 and 9, and maintained performance for indicator 10. With sustained performance, it is likely that these three indicators can move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	187	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 10/10	1/1	1/1	1/1	1/1	2/2	1/1	2/2	1/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 10/10	1/1	1/1	1/1	1/1	2/2	1/1	2/2	1/1	
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	90% 9/10	1/1	1/1	1/1	0/1	2/2	1/1	2/2	1/1	
Comments: 10. For Individual #262 UIR 16-091, the investigation identified a probable cause of the injury, but it did not have direct evidence to											

support this. The UIR stated that this discovered injury had a determined cause, but it did not, it had a probable cause. To classify a discovered injury as having a determined cause, discovery of direct evidence in the course of the investigation must be found.

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: The facility maintained 100% performance for indicator 11 for this and the previous two reviews. Therefore, this indicator will be moved to the category of requiring less oversight. The facility showed improved performance on indicators 12 and 13 since the last review. With sustained performance, it is possible these two indicators can move to the category of requiring less oversight after the next review, too.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	187	
11	Commenced within 24 hours of being reported.	100% 10/10	1/1	1/1	1/1	1/1	2/2	1/1	2/2	1/1	
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	90% 9/10	0/1	1/1	1/1	1/1	2/2	1/1	2/2	1/1	
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	90% 9/10	1/1	1/1	1/1	1/1	2/2	1/1	2/2	0/1	

Comments:

12. For Individual #109 UIR 2648, interviews of witnesses did not occur as per policy, but the UIR did not indicate the reason why. This did not, without further explanation, demonstrate extraordinary circumstances.

13. For Individual #187 UIR 2404, the supervisory review did not attempt to reconcile the time discrepancy as to when the incident was actually reported. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.	
Summary: San Antonio SSLC showed 100% performance on these indicators during this review and the last two reviews. Given this sustained performance, these two	Individuals:

indicators will move to the category of requiring less oversight.											
#	Indicator	Overall Score	109	290	95	262	41	214	84	187	
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 2/2	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A	
Comments:											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: The facility maintained good performance for indicator 16 for this review and the previous two reviews. During this review, performance for indicators 17 and 18 was lower than during the previous two reviews. All three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	187	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	2/2	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	83% 5/6	1/1	1/1	N/A	1/1	N/A	N/A	2/2	0/1	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	71% 5/7	1/1	N/A	1/1	0/1	1/1	N/A	2/2	0/1	
Comments: 17-18. For Individual #262 UIR 16-091, there was no documentation provided to validate one of the three recommendations occurred. This was recommendation number 3 regarding placing a work order to provide padding. For Individual #187 UIR 2404, the UIR described eight future actions and the DFPS report described one recommendation. Insufficient documentation was provided to validate that all nine recommended actions actually occurred.											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.	
Summary: This outcome consists of facility indicators. The facility had been doing quality assurance reviews for some time. The review for incident management-related items was not containing longitudinal reviews, data, or documentation of follow-up. The IMC should work closely with the QA director on this. If so,	Individuals:

performance on these indicators is very likely to meet criteria at the time of the next review. These will remain in active monitoring.											
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	No									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									
Comments: 20-23. The facility's trend reports and QAQI Council minutes narratives only addressed the most current month and did not address longitudinal trends. The narratives that addressed the current month were acceptable and tended to identify issues and intended actions to address issues. This was good to see, but even so there were no data (month to month) to determine if the predicted outcomes described in one month had the intended effect (e.g., the May 2016 report did not address the predicted outcomes described in the April 2016 report). Similarly, the QAQI Council minutes contained a column for follow-up required, but for both the May 2016 and June 2016 minutes, there were no entries in this column.											

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. The Center had a draft policy entitled: "San Antonio - Dental Services: General (TIVA) Anesthesia – Criteria for Use," draft											

revised 11/3/14, which included dental criteria for selection of individuals for TIVA. This policy provided guidance as to which individuals would benefit from dental care under TIVA/general anesthesia. Although some dental criteria for TIVA were outlined, these often were not measurable criteria, and were not consistent with those included in the Dental Audit Tool [i.e., the following procedures must be anticipated: Deep Cleaning (D4341/D4342), Restorative (D2140-D2999), Endodontics (D3110-D3999), and Extractions (D7111-D7999). There are some procedures, such as pulling wisdom teeth or deep scaling that people in the community would expect some form of sedation. For other procedures, three failed attempts must occur first before TIVA is used. If the individual met this criterion before and has another dental need, then only one failed attempt would be necessary, utilizing any desensitization or other strategies developed for the individual. The dentist should describe in detail what issues were observed during the trials. The only exceptions to this would be emergencies. Even if there are failed attempts, teams should document discussion of the need for programmatic interventions to increase cooperation in the future.]. The Facility should modify its policy to be consistent with these guidelines.

The Center had a policy related to obtaining medical clearance from the PCP or specialists as indicated. It was entitled: " San Antonio – Dental Services: Dental Services: General (TIVA) Anesthesia – Medical Clearance," implemented 2/23/14. Medical clearance was confirmed for these two individuals.

For these two instances of use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and post-operative vital sign flow sheets were completed.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
	Comments: Based on documentation the Facility submitted, in the six months prior to the onsite review, none of the individuals the Monitoring Team responsible for physical health reviewed had medical pre-treatment sedation.										

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.	
Summary: IDTs were discussing some aspects of PTCR for some individuals (one out of four in this review). In this one cases, treatments or strategies were created, implemented, and monitored, though no changes were made when needed. All of these indicators will continue to receive active monitoring.	Individuals:

#	Indicator	Overall Score	95	262	41	214					
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	25% 1/4	1/1	0/1	0/1	0/1					
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	25% 1/4	1/1	0/1	0/1	0/1					
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	100% 1/1	1/1	N/A	N/A	N/A					
4	Action plans were implemented.	100% 1/1	1/1	N/A	N/A	N/A					
5	If implemented, progress was monitored.	100% 1/1	1/1	N/A	N/A	N/A					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1	0/1	N/A	N/A	N/A					

Comments:
1-6. This outcome and its indicators applied to Individual #95, Individual #262, Individual #41, and Individual #214. Four individuals received TIVA in the last year for dental procedures.

1. There was evidence that Individual #95's IDT discussed PTCR usage and effectiveness, behaviors observed during the procedure, other supports and interventions provided, additional supports or interventions that could be provided for future appointments, and the risk and benefit of the procedure without PTCR versus with PTCR. Additionally, there was informed consent from the LAR/Facility Director. Individual #262, Individual #41, and Individual #214 did not have evidence of supports and interventions provided and additional supports or interventions that could be provided for future appointments or the risk and benefit of the procedure without PTCR versus with PTCR.

2. There was documentation that a SAP to improve oral hygiene and, therefore, reduce the need for TIVA for future dental interventions, was developed for Individual #95. There was no evidence of an action plan to reduce PTCR usage, or a determination by the IDT that any actions to reduce PTCR would be counter-therapeutic, for Individual #262, Individual #41, or Individual #214.

3. Only Individual #95 had treatments or strategies to reduce the use of PTCR. Her treatment was a SAP to improve her oral hygiene to prevent the future need for TIVA.

4-5. Individual #95's action plan was implemented and progress was monitored. 6. Individual #95 was not progressing on her toothbrushing SAP and no action to address the lack of progress was evident.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.												
Summary: Although timeliness of mortality reviews was good, significant work was needed to critically review deaths and identify areas in which changes could be made to improve the care and treatment the Center provides. The Monitoring Team will continue to assess these indicators.			Individuals:									
#	Indicator	Overall Score	149	90	165	306						
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1						
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1						
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1						
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1						
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1						
Comments: a. Since the last review, four individuals died. The Monitoring Team reviewed all four deaths. Causes of death were listed as: • Individual #149 – aspiration pneumonia; • Individual #90 – unspecified heart failure; • Individual #165 – end stage septicemia; and • Individual #306 – septic shock, and acute respiratory failure.												

b. through d. Some of the concerns with regard to recommendations included:

- Evidence was not submitted to show the Facility conducted thorough reviews of nursing care, or an analysis of medical/nursing reviews to determine additional steps that can be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.
- Overall, some of the problems with the Nursing QA Mortality Reviews included: 1) the reviews lacked sufficient information to support the findings; 2) they did not reflect a comprehensive review of nursing care and practices; 3) for individuals that died during a stay of more than 72 hours at the hospital, the reviews provided no information about the care the Facility provided the individual (i.e., for individuals who are hospitalized, instead of discussing care 72 hours prior to death, the reviews should evaluate care provided 72 hours before the individual's transfer to hospital); and 4) the QA Nurse Mortality review template did not support performance of a comprehensive review.
- The Center submitted an external medical review of the death of Individual #149. However, this review was not signed or dated. Therefore, it could not be determined who conducted this review.

e. The information the Center submitted with regard to mortality review recommendations was not responsive to the Monitoring Team's document request. More specifically, the Center did not initially submit a summary log of recommendations. Rather, items such as medical literature and Center policies were submitted along with training rosters for medical and nursing staff. However, the purpose of this information was unclear without a link to a specific recommendation. After the onsite review, the Monitoring Team requested further information. The various documents submitted did not match in terms of number or content of recommendations. In addition, the documents were not dated, making it difficult to reconcile the differences.

The Center should maintain (as do other SSLCs) a summary log of mortality recommendations. The log should include the recommendation being implemented, the responsible parties, actions steps, and the date of closure. Documentation of implementation of these recommendations, such as training documentation, monitoring results to show that outcomes have changed and/or problematic practices have been corrected, and other evidence of follow-up and/or closure should be submitted as stated in the Monitoring Team's document request.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: These indicators will be reviewed until the Center's quality assurance/improvement mechanisms related to ADRs can be assessed and are deemed to meet the requirements of the Settlement Agreement.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	ADRs are reported immediately.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1

b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/1									0/1
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 1/1									1/1
d.	Reportable ADRs are sent to MedWatch.	N/A									N/A

Comments: a. through c. Per the ADR report, on 5/31/16, it was reported that Individual #115 developed sedation following the placement of a 5% lidocaine patch. The patch was placed on 5/28/16, at 8 a.m. Around noon, the individual was noted to have an irregular and shallow pulse with oxygen saturation of 88%. The heart rate was 92, respirations 28, and blood pressure 124/70. At 12:15 p.m., the individual was reported to be sleeping deeply, but was easy to arouse and resumed his normal activities after awakening. This was determined not to be an ADR. It was disconcerting to find that there was no documentation in the IPNs by the medical provider regarding this incident. On 6/1/16, the patch was re-started without incident.

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.

Summary: The Center needs to focus on completing DUEs that are consistently clinically significant. In addition, recommendations should be generated, as appropriate, and followed through to closure.

#	Indicator	Score
		Individuals:
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	57% 4/7
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/7

Comments: a. and b. In the six months prior to the review, San Antonio SSLC completed seven DUEs. Four of the DUEs provided very good assessments of drug utilization for clinically relevant topics. Other evaluations did not meet the criteria for a proper DUE. The Center should focus on the purpose of conducting DUEs as noted in Appendix A of the Health Care Guidelines. More specifically: "The goal of DUE is to assure the appropriateness, safety and effectiveness of medication use. The evaluation should cover all medications in the state's drug formulary, with priority given to high-risk and high use medications. The evaluation should also address indications, absolute and relative contraindications, screening thresholds, and adverse effects, as described in the state's drug formulary."

The following describes the DUEs the Center completed that were clinically relevant:

- Risperidone, dated 12/15/15. Per the DUE Summary, this was a follow-up DUE completed to assess progress for being in compliance with recommended dosing and monitoring guidelines. Thirty-seven percent of individuals receiving risperidone had doses that placed them at increased risk of extrapyramidal symptoms, which increases the risk for development of involuntary movement disorders. The two primary recommendations were to monitor for side effects and ensure that a clinical rational is documented for continued high dose use. It would appear prudent that the Center have a formal mechanism for reviewing the individuals identified as at risk in order to ensure the appropriate clinical justification was present. The Pharmacy and Therapeutics (P&T) Committee notes did not present a specific plan of action. The P&T Committee Meeting

notes did not discuss any recommendations or action plans generated by the DUE.

- Probiotic utilizaion, dated 12/31/15. This was a follow-up DUE. Per the summary, the data showed an increase in the use of probiotics since 2013. Since 80% of antibiotic regimens also included a probiotic, the recommendation was to continue to emphasize the use of probiotics with antibiotics. The P&T Committee Meeting notes did not discuss any recommendations or action plans generated by the DUE.
- Lipid therapy, dated 5/1/16. Per the DUE report, while reviewing dyslipidemia guidelines in Continuous Quality Improvement (CQI), in February 2016, it was recommended to evaluate individuals treated for dyslipidemia to determine if they are treated to goal. Data was used to calculate the 10-year Cardiovascular Risk using online calculators. The conclusion was that the majority of individuals are treated to goal based on their 10-year risk. There were two recommendations: 1) maximize therpay for individuals not currently at target cholesterol; and 2) document in annual medical summary or interval note for individuals where the risks of maximizing therapy outweigh the benefit. It was good to see the Center taking the necessary actions to apply the American College of Cardiology (ACC)/American Heart Association (AHA) guidelines for risk assessment. The calculator used in the study calculates the 10-year estimate risk for individuals with no history of atherosclerotic cardiovascular disease (ASCVD) to determine if statin therapy is indicated. When statin therapy is indicated (risk greater than or equal to 7.5%), either high or moderate intensity therapy is utilized based on the clinical scenario. High-dose therapy lowers low-density lipoprotein (LDL) cholesterol by approximately 50%, while moderate intensity lowers LDL by 30 to 50%. The AMA and/or interval summary should clearly document the risk assessment, the clinical scenario that determines the intensity of treatment, and the expected outcome with regards to LDL. Again, there was no plan of action to ensure that the recommendations were implemented.
- Angiotensin-converting enzyme (ACE) inhibitors and angiotensin-receptor blocker (ARBs) in patients with diabetes mellitus, dated 5/27/16. The objective was to evaluate compliance with the use of ACE/ARBs for renal protection in individuals with diabetes. The recommendation was for the PCP to evaluate individuals with diabetes mellitus in their caseloads to determine if renal protection with an ACE/ARB is appropriate. While this information is of great clinical significance, the monitoring of this data should be a part of an ongoing medical quality program. There should be periodic reviews of all individuals with diabetes mellitus to determine if the care is consistent with the American Diabetes Association (ADA) standards of medical care in diabetes.

The following were not considered clinically relevant:

- Adderall and proton pump inhibitors (PPIs), dated 12/24/15. The objective was to identify individuals affected by drug interactions between Adderall and PPIs. There were no individuals receiving this combination of drugs. The Center should have been able to identify the affected cohort based on pharmacy profiles. A study sample of zero would indicate there was no need for this DUE. The P&T Committee Meeting notes did not discuss any recommendations or action plans generated by the DUE.
- Aspiration pneumonia and PPIs, dated 3/17/16. The objective of this DUE was not clear. However, the determination of a relationship between aspiration pneumonia and PPIs requires an adequate sample size and proper study design. Conducting observational studies, such as case control studies, requires the proper application of several principles of epidemiology, including a through understanding of confounding factors and the application of statistical analysis. The study correctly concluded that the "data set was not properly powered to determine reliable results." No recommendations were generated.
- Antipsychotics in Parkinson's Disease, dated 3/31/16. The objective was to determine if any individuals at SASSLC were

	currently diagnosed with Parkinson's Disease and treated with antipsychotics. Four individuals were diagnosed with Parkinson's disease and only one received psychotropic medication. Again, this information should have been determined by existing data and review of medication profiles. The clinical relevance of this DUE was not clear.

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

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

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

<u>Assessments</u>

For the individuals' risks reviewed, none of the IDTs effectively used supporting clinical data (including comparisons from year to year), used the risk guidelines when determining a risk level, and/or as appropriate, provided clinical justification for exceptions to the guidelines. As a result, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting for most individuals. IDTs, however, did not then arrange for and obtain needed, relevant assessments prior to the IDT meeting. Many were late or missing.

Medical Department staff should focus on improving the quality of medical assessments. Areas requiring improvement included ensuring medical assessments, as appropriate, include pre-natal histories, describe family history, identify childhood illnesses, incorporate pertinent laboratory information, and include updated active problem lists, and plans of care for each active medical problem, when appropriate.

Since the last review, Center had improved the timeliness of the dental summaries. However, work was still needed with regard to the timeliness of dental exams, as well as the quality of dental exams and summaries.

Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the

chronic conditions and promote amelioration of the at-risk condition to the extent possible. In addition, often, when individuals experienced changes of status, nurses did not complete assessments consistent with current standards of practice.

In addition to timely referrals to the PNMT, work is needed to ensure that PNMT reviews are complete and thorough, and that they recommend comprehensive assessments as appropriate to meet individuals' needs. When comprehensive assessments are completed, it is essential that the PNMT identify, whenever possible, the potential cause(s) of the physical and/or nutritional problem, and offer clinically justified recommendations, including, but not limited to recommendations for goals/objectives, as well as strategies to address the problem.

Comprehensive psychiatric evaluations were done for each individual and they were formatted correctly, however, all lacked sufficient bio-psycho-social formulations. Annual evaluation updates were not completed. Psychiatry related goals did not link the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status.

Functional assessments and PBSPs were up to date and complete, for the most part. PBSPs were in place for all individuals who needed a PBSP. There were individualized, measurable goals that were based upon assessments. Moreover, reliable data existed for most individuals, too.

Focus is needed on skill acquisition programs being practical, functional, and meaningful. A new pilot program to improve SAP meaningfulness, comprehensiveness, quality, and implementation was being initiated at San Antonio SSLC.

<u>Individualized Support Plans</u>
ISPs should contain personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. One individual had personal goals based on his preferences in four of the six ISP focus areas. This was good to see. Overall, IDTs were struggling with developing individualized meaningful measurable goals for individuals. There was little focus on opportunities to develop new skills and gain exposure to new experiences.

Action plans need to support the achievement of personal goals. One living option goal had action plans that would support achievement of the goal. When looking at the set of action plans, preferences and opportunities for choice were not well-integrated, they did not assertively promote enhanced independence, and meaningful and substantial community integration was largely absent. More work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. QIDPs did not ensure that the individual received required monitoring/review and revision of treatments, services, and supports.

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: San Antonio SSLC had recently completed training in the new ISP process. ISPs did not yet set goals that were individualized and met the criteria for this outcome. One ISP, however, included some goals that met criteria. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	95	262	84	326	217			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	4/6	0/6	0/6	0/6	0/6	1/6			
2	The personal goals are measurable.	0% 0/6	4/6	0/6	0/6	0/6	0/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #95, Individual #262, Individual #326, Individual #217, Individual #84, and Individual #109. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the San Antonio SSLC campus.

1. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

Overall, outcomes for five of the six ISPs remained very broadly stated and general in nature and/or were very limited in scope. None had individualized goals in all areas.

Individual #109, however, had individualized goals based on his preferences in four of the six ISP focus areas. This was good to see.

Although goals in all six areas are required for meeting criterion with this indicator, this ISP showed good progress for the San Antonio SSLC. For example, his employment goal was to work part-time in the community, his goal to increase independence was to do his laundry, and his recreation goal was to go fishing.

Review of ISPs and observation of IDT meetings indicated that staff were still struggling with developing individualized meaningful measurable goals for individuals. Additionally, goals primarily focused on compliance issues and skill maintenance. There was little focus on opportunities to develop new skills and gain exposure to new experiences. Examples that did not meet criterion were:

- Individual #95's leisure goal stated that she would be provided with opportunities to attend leisure activities and her goal to support greater independence stated that she will increase her independent living skills.
- Individual #262 had a number of broad-based goals that were not individualized, including her living option goal to "receive" community awareness and her relationship goal to interact with her peers,
- Individual #326 did not have a leisure goal, though her ISP documented she that enjoyed leisure activities. Her day program goal was deferred for now. It was not clear how she would be supported to be engaged in meaningful activities during the day.
- Individual #217 did not have a leisure or relationship goal. Even though she was not working, the IDT determined that these were not priority areas for her.
- Individual #84's living option goal stated that he would live in the most integrated setting consistent with his preferences, strengths, and needs. His relationship goal was to work on improving his relationship with peers.

The facility may want to consider seeking additional assistance from state consultants or perhaps developing an internal peer review process to focus on the goal development process. Internal peer review might involve QIDPs presenting the goals from their most recent ISP to the other QIDPs, the QIDP educator, and the QIDP coordinator and getting feedback on the goal and its underlying action plans.

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

The Monitoring Team acknowledges that the development of personal goals that will meet criteria is a work in progress at all facilities. More guidance is expected from state office. Moreover, the QIDP coordinator and the QIDP educator will be very important in supporting teams to make goals that meet criterion for compliance. To do so, they will need to provide a lot of feedback to the QIDPs and to other team members.

3. In most cases, personal goals were not individualized or measurable, so there was no basis for assessing whether reliable and valid data were available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals.

For the goals that did meet criterion, there was not reliable and valid data on implementation of the plans to address the goals. Review of data implementation sheets, ISP preparation documentation, and QIDP monthly reviews indicated that consistent data were not collected for most ISP action plans.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.												
Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met, but in a handful of cases. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	109	95	262	84	326	217				
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	0/6	0/6	0/6	0/6	0/6				
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1				
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
11	ISP action plans supported the individual's overall enhanced independence.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1				
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1				
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1				
17	ISP action plans were developed to address any identified barriers to achieving goals.	33% 2/6	1/1	0/1	0/1	0/1	0/1	1/1				
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	1/6	0/6	0/6	0/6	0/6	0/6				
Comments: Once San Antonio 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.												

8. For the most part, personal goals did not meet criterion in the ISPs as described above in Indicator 1. Therefore, action plans cannot be evaluated in this context. A personal goal that meets criterion is a pre-requisite for such an evaluation. Action plans are evaluated below in terms of how they may address other requirements of the ISP process.

Of the personal goals that were individualized and measurable, only one (Individual #109's living option goal) had action plans that would support achievement of his goal.

In addition, the Monitoring Team requested (and received) the goals and action plans for the two annual ISPs that were observed during the onsite week, that is, for Individual #207 and Individual #6. Both sets of goals did not meet criteria for indicator 1 and, moreover, the underlying action plans did not support the goals (such as they were) and/or were not even related to the goal.

9. Individual #217 had action plans to use augmentative communication devices to express her choices. Overall, preferences and opportunities for choice were not well-integrated in the individuals' ISPs. Examples included:

- Individual #95's ISP offered her opportunity to choose between contracts at work, however, it was not evident that choices were based on her preferences. Her PSI was not completed prior to her annual ISP meeting.
- Individual #109 had little control over his day and no opportunities for choice. The team recommended further assessment of his vocational interests, but it was not evident that the assessment was completed.

10. ISP action plans not did comprehensively address identified strengths, needs, and barriers related to informed decision-making for individuals.

11. Overall, action plans did not assertively promote enhanced independence for any of the individuals. Individual #95, Individual #262, Individual #84, and Individual #109 had action plans to promote greater independence that appeared to address compliance rather than develop new skills. Individual #326 had a walking program to increase her independence and Individual #217 had a communication SAP to increase her independence. In both cases, these skills were identified as barriers to being more independent.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans. Examples included:

- Individual #95's ISP did not document discussion regarding her risk for chemical restraint, though chemical restraint had been administered numerous times during the review period.
- Individual #262's renal risk was not adequately addressed by her IDT.
- Individual #326 had not had recommended preventative care screenings. The team had not discussed the lack of screenings. In addition, Individual #326 was taking a beta-blocker. There was no documentation of the need to monitor his heart rate/pulse prior to medication administration.
- Individual #109 wore a soft helmet. It was not part of his PBSP or PNMP. He was a relatively new admission and he had the helmet when he was admitted. No efforts were made to reduce or eliminate his wearing of the helmet.
- The Monitoring Team attended the annual ISP of Individual #6. He had Down Syndrome, but there was no discussion of his risk for Alzheimer's Disease/dementia. IDT members were not aware of the connection between these conditions.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated. In addition to the examples provided in indicator 12 above, integration of psychiatry supports was not evident for any of the individuals reviewed. There did appear to be attempts to integrate communication and behavioral supports for some individuals.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were no specific plans for community participation that would have promoted any meaningful integration for any individual.

15. Only one of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #109 had a goal to obtain part-time employment in the community.

- Individual #95 was scheduled to attend the workshop daily, however, observations did not support that she routinely attended or, when she did attend, that she had any interest in the contracts available to her.
- Individual #262's IDT did not discuss vocational options or opportunities to learn new work skills based on her preferences and skills. She was observed to easily complete tasks given to her at the workshop. Staff reported that she was a good worker and could complete most task presented to her.
- Individual #326's ISP indicated that she enjoyed activities in the community. Her action plans did not include opportunity for her to routinely participate in community activities.
- Individual #217's ISP noted that she needs more time in the community. Action plans were not developed to address this recommendation.
- Individual #84's ISP did not document discussion of opportunities for employment based on his preferences and strengths in a more integrated setting.

16. One of six individuals had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs.

- Individual #84's ISP indicated that he worked at the workshop in the morning and afternoon. The facility reported his attendance was around 90%.
- Individual #109 was recently admitted to the facility; the team recommended further vocational assessment. He was working at the workshop though observation did not support full time attendance. There was no evidence that he had been assessed for vocational preferences.
- Observations did not support that Individual #95 was functionally engaged during the day.
- There was not sufficient information in Individual #262's ISP to support functional engagement during the day.
- Individual #326's ISP noted that her day/work goals were deferred. She had one action plan to sing a song during day programming.
- Individual #217's ISP included minimal information regarding how she would spend her day. It was noted that she had little variety and little control over her programming. It further noted that she attended activity off the home when a nurse was available.

17. Barriers to various outcomes were not consistently identified and addressed in the ISP. Individual #84 did have a PBSP that addressed barriers to living in a less restrictive environment. Individual #217's IDT discussed barriers to her attending programming

and participating in more community outing (transportation and nursing services). Her ISP also included action plans for developing additional communication skills, noted to be a barrier to her independence. 18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs were often missing key elements, as described elsewhere in this report. Living options action plans generally had no measurable outcomes related to awareness and no criteria for completion or frequency.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: Criterion was met for some indicators for some individuals, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	95	262	84	326	217			
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).	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	67% 4/6	1/1	0/1	1/1	0/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	50% 3/6	1/1	0/1	0/1	1/1	0/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

	individual was currently referred, to transition.										
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	0% 0/4	N/A	0/1	0/1	N/A	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. One of six ISPs included a description of the individual's preference and how that was determined. For three individuals (Individual #326, Individual #262, Individual #217) preferences were described as unknown. Individual #84's ISP described his LAR's preferences but not his. Individual #109's ISP described his past experiences, however, there was no discussion regarding what his preferences were or what he wanted in the future. He did have a goal to live "in a big house in the community," but that offered little guidance for planning. Individual #95's ISP included a good discussion of her preferences and how they were determined.

20. At Individual #6's ISP meeting, his preferences of where to live were not discussed. It was likely that he would not have been able to express his preferences, but efforts to understand the characteristics of his preferred living setting were not discussed.

21. Two of six ISPs fully included the opinions and recommendation of the IDT's staff members. For the remaining four, input from the psychiatrist was absent. For those four, behavioral issues were considered the greatest barrier to community placement. Input from the psychiatrist would have been relevant and helpful in determining supports needed in the community. The only rationale statement from Individual #95's IDT was from the nutritionist. Individual #84's IDT did not document recommendations from individual team members.

22. Four of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Those that did not accurately reflect the basis for the decision were the following:

- The rationale for the IDT's decision not to refer Individual #95 was not clearly stated.
- Individual #84's ISP did not include documentation of input from IDT members.

23. Three of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #95, Individual #262, and Individual #326's ISP did not include documentation of a thorough discussion regarding other options that may be available based on their preferences and support needs.

24. All ISPs had a completed checklist of barriers to community placement. It would, however, be beneficial for planning if the ISP included more detail regarding barriers. For example, all of the ISPs noted behavior or medical issues that precluded consideration of a referral. In some cases, it was not clear what the specific behavior or medical issue was that could not be supported in the community.

25. At Individual #6's ISP meeting, obstacles to referral were not identified.

26. One of six individuals who were not referred had individualized, measurable action plans to address identified obstacles to referral. Individual #84's PBSP included measurable action plans to address behaviors noted to be a barrier to community placement.

27. At Individual #6's ISP meeting, there were no obstacles identified for which an action plan could be developed. However, during the meeting, the LAR (parent), who had been opposed to any community referral, asked about the possibility of family home care. The IDT responded to this very positively and said they would follow-up with the family and provide more information.

28. For four individuals, action plans to educate the individual and /or LAR were not individualized or measurable. Individual #84 and Individual #109 were both familiar with community living options.

29. All individuals had obstacles identified at the time of the ISP.

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

Summary: ISPs were developed in a timely manner, but not implemented. Individuals participated in their ISP preparation and annual meetings, but not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	95	262	84	326	217			
30	The ISP was revised at least annually.	80% 4/5	N/A	1/1	0/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
30-31. Five of six ISPs were developed on a timely basis. Individual #262 was in the hospital at the time of her scheduled ISP annual meeting. Her meeting was delayed for two months due to her illness.

32. The Monitoring Team was unable to confirm that all action plans and supports included in the ISP were implemented within 30 days due to the absence of QIDP monthly review of supports and services. Individual #217 was the exception. Her March QIDP monthly review documented the implementation of action plans and other supports and services as described in her ISP.

33. Six of six individuals attended their ISP meetings.

34. Individuals did not have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples included:

- No attendance by the psychiatrist at Individual #95, Individual #262, Individual #84, and Individual #109's annual meeting and no assessment completed prior to the meeting.
- No participation by the PCP at Individual #217's meeting even though she had very complex medical needs that impacted her programming and supports.
- No participation by Individual #326's family. Her ISP indicated that her family was involved and advocated on her behalf.

At the two annual ISPs observed by the Monitoring Team during the onsite week, for Individual #207 and Individual #6, there was good participation from their PCPs, but on the other hand, the DSPs who were present were not brought into the conversation as much as they could/should have been.

Outcome 6: ISP assessments are completed as per the individuals' needs.												
Summary: Assessments that were needed were considered and identified by the IDTs for four of the six individuals. For all individuals, assessments were not always obtained prior to the ISP meeting. Both indicators were scored lower than the last review. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	109	95	262	84	326	217				
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	67% 4/6	1/1	1/1	0/1	0/1	1/1	1/1				
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for four individuals. Individual #109 was recently admitted, so did not have an ISP preparation meeting. The team did, however, arrange to have a number of relevant assessments completed prior to his initial ISP meeting.

For Individual #84, the ISP preparation documentation did not indicate that the team considered a psychiatric evaluation prior to his ISP meeting. Individual #262's team did not consider an assessment to determine the status of her renal disease, therefore, the IDT did not have information available to adequately address her risks.

36. IDTs did not arrange for and obtain needed, relevant assessments prior to the IDT meeting. Late or missing assessments included:

- For Individual #95: Medical, Pharmacy, Psychiatry, FSA, and PSI.
- For Individual #262: Psychiatry and PSI

- For Individual #326: Psychiatry and PSI
- For Individual #217: Psychiatry and PSI
- For Individual #84: Psychiatry and PSI
- For Individual #109: Psychiatry, PSI, and Vocational

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	95	262	84	326	217			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

Comments:

37. IDTs generally met when the individual experienced some type of regression or change in status, but they rarely used data to make decisions about revising the ISP. As noted throughout this report, consistent reliable data were not available to help teams determine if supports were effective and if the individual was making progress. It was not evident that IDT members always reviewed supports and took action as needed when individuals failed to make progress on outcomes, experienced regression, or refused to participate. For example:

- For Individual #95, consistent data were not submitted for her GERD, sleep, or emesis. Decisions for treatment appeared to be made based on anecdotal evidence.
- Although Individual #262 had experienced significant changes in her functional status following her surgery, her ISP was not reviewed and revised to reflect her changing support needs.
- Individual #326, Individual #84, and Individual #217's ISP preparation documentation indicated that recommendations were made to discontinue, revise, or continue supports without data available for review.
- Individual #109 had no monthly review of supports.

38. QIDPs did not ensure that the individual received required monitoring/review and revision of treatments, services, and supports. QIDPs were interviewed and found to be knowledgeable, to a degree, about some aspects of individuals' preferences and strengths, but were also often not able to articulate the status of various action plans and supports. In most cases, consistent implementation, progress, and/or regression could not be determined due to missing data. It was not evident that reviews resulted in action taken when ISPs were not implemented or not effective. QIDP monthly reviews were not comprehensive and did not review the status of all supports. Individual #217 was the only individual with a full six months of QIDP monthly reviews. Her monthly reviews did include data on action plans and a minimal review of all supports.

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	The individual's risk rating is accurate.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #95 – constipation/bowel obstruction, and weight; Individual #262 – weight, and seizures; Individual #217 – gastrointestinal (GI) problems, and infections; Individual #326 – constipation/bowel obstruction, and seizures; Individual #222 – seizures, and other: pain; Individual #220 – constipation/bowel obstruction, and seizures; Individual #306 – GI problems, and weight; Individual #151 – constipation/bowel obstruction, and seizures; and Individual #115 – constipation/bowel obstruction, and seizures]. a. For the individuals reviewed, IDTs did not effectively use supporting clinical data, use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. b. Overall, IDTs did not update IRRFs with relevant information annually. It was also concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate.											

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: The development of individualized psychiatric goals was being addressed by state office. Over the next few months, those activities should impact San Antonio SSLC's psychiatric goals and move them towards meeting criteria with these indicators. The ongoing changes in the psychiatric provider staff also competed with the ability for the facility to make progress on these indicators. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187

4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors, such as aggression. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. The data will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

Psychiatric progress notes did not document review of data. In some cases, data presented were stale. For example, for the quarterly psychiatric clinic dated 3/23/16 regarding Individual #41, data were presented only through the end of February 2016. In only one example, regarding Individual #199, was there psychiatric documentation of the presentation and review of data, but because this was not related to a psychiatric goal, it was scored as not meeting criterion, too.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: CPEs were done for each individual and they were formatted correctly. This has been the case at San Antonio SSLC for some time now. These two indicators will move to the category of less oversight. There remained a need for improvement in CPE content as well as the documentation required for indicators 15 and 16. The latter two indicators showed some improvement from the time of the last review. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	290	95	262	41	214	84	199	187
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
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.	20% 1/5	0/1	0/1	N/A	0/1	N/A	N/A	1/1	N/A	0/1
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:

14. The Monitoring Team looks for 14 components in the CPE. All of the evaluations lacked sufficient bio-psycho-social formulations. This was the most common deficiency. One evaluation was lacking sufficient information in a total of four elements, one evaluation was lacking sufficient information in three elements, three evaluations were lacking sufficient information in two elements, and four evaluations were lacking sufficient information in one element.

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

16. There was a need for improvement with regard to the consistency of diagnoses for two individuals, in particular between the annual medical assessment and the psychiatric documentation.

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

Summary: Annual psychiatric updates were not being conducted and there was little evidence of psychiatrist participation in the ISP process. All five of these indicators had zero or low scores at this review as well as at the last two reviews, too. This outcome and its indicators should be a focus of the psychiatry department; all indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	290	95	262	41	214	84	199	187
17	Status and treatment document was updated within past 12 months.	0% 0/6	N/A	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/6	N/A	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
20	The psychiatrist or member of the psychiatric team attended the	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	individual's ISP meeting.	0/9									
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
17-18. The Monitoring Team scores 16 aspects of the annual evaluation document. Six individuals required annual evaluations. In no case example, was this evaluation performed.

19. Because the annual comprehensive psychiatric evaluations were not completed, they were not available for review at the ISP. In some examples, the ISP document noted that there was no psychiatric assessment reviewed (Individual #109, Individual #290). In other examples, specifically Individual #84 and Individual #187, there was documentation of a review of the psychiatric treatment plan and the initial CPE, respectively.

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

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

Summary: This indicator will remain in active monitoring. Individuals:

#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A

Comments:
22. Per the ISP regarding Individual #262, 2/29/16, a PSP was pending. This had yet to be completed.

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

Summary: Indicators 28, 29, and 32 showed improvement since the last review. With sustained performance, they might move to the category of requiring less oversight after the next review. Indicators 30 and 31, however, remained at low scores for this and the last two reviews. Note, however, that criteria for all five indicators were met for one individual. This was good to see. Individuals:

#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187

28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:
28. The facility had transitioned to the revised consent form. With regard to Individual #262, the consent form for Cogentin was not provided for review.

29. The facility had made the transition to a revised version of the consent form. These consent forms included adequate side effect information.

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

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.

Summary: San Antonio SSLC ensured that every individual who needed a PBSP had a PBSP and that the PBSPs had goals/objectives as per criteria and that goals/objectives were measurable. This had been the case at the facility for a number of consecutive reviews and, therefore, indicators 1, 2, and 3 will move to the category of requiring less oversight. Sustained high performance for indicator 4 will likely result in that indicator moving to the category of requiring less oversight after the next review. The facility showed excellent progress and performance in the establishment and collection of reliable data. Indicators 4 and 5 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	290	95	262	41	214	84	199	187
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	100% 11/11	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	impede his or her growth and development, the individual has a PBSP.										
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	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, 11 required a PBSP (nine individuals reviewed by the behavioral health Monitoring Team and two individuals reviewed by the physical health Monitoring Team). All 11 individuals had PBSPs.

2-4. All individuals with a PBSP had measurable objectives related to behavioral health services that were based on assessment results

5. Eight individuals had evidence of interobserver agreement (IOA) and data collection timeliness assessments in the last six months that were at or above 80%, indicating that their PBSP data were reliable. Individual #214 did not have IOA and data collection timeliness assessments in the last six months. Documentation that PBSP data are reliable represented a dramatic and positive improvement at San Antonio SSLC.

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

Summary: An area of focus for the facility is to ensure that behavioral health assessments are complete and up to date. Functional assessments were current and complete and had been for the past two reviews, too. Therefore, these two indicators, 11 and 12, will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 109	290	95	262	41	214	84	199	187
10	The individual has a current, and complete annual behavioral health update.	75% 6/8	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	N/A
11	The functional assessment is current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
12	The functional assessment is complete.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A

Comments:
Criteria for indicators 1-9 were met for Individual #187. This was good to see. Therefore, indicators 10-30 in psychology/behavioral health were not rated for him.

10. Individual #95 and Individual #214 did not have an assessment of intellectual functioning in their behavioral health assessment, therefore, they were scored as incomplete.

11-12. All individuals had current and complete functional assessments.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: PBSPs at San Antonio SSLC were current and had been for some time. Therefore, indicator 14 will move to the category of requiring less oversight. Ensuring implementation within 14 days of consent is an area that needs some focus. PBSPs were for the most part complete. These two indicators, 13 and 15, will remain in active monitoring, but with improved performance, may move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	75% 6/8	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	N/A
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
15	The PBSP was complete, meeting all requirements for content and quality.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	N/A

Comments:
13. Six individuals' PBSPs were implemented within 14 days of attaining consents, however, Individual #214 and Individual #290's PBSPs were not implemented within 14 days of attaining consents.

14-15. All PBSPs were current and 88% were complete. The exception was Individual #84's replacement behavior, which was noted to occur only a few times a month. Therefore, his PBSP was scored 0 because he did not have sufficient opportunities for the behavior to be useful.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: These indicators were scored at 100% during this review and for the past two reviews. Thus, both indicators of this outcome, 24 and 25, will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall	109	290	95	262	41	214	84	199	187

		Score									
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2	1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 2/2	1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
Comments: 24-25. Individual #84 and Individual #109 were referred and received counseling services. Both treatment plans and progress notes were complete for Individual #84. Individual #109 had a complete treatment plan, however, he did not progress notes to review because his therapy just began last month.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Indicator b will continue in active oversight. The remaining indicator for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
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.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	N/R									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.	
Summary: Medical Department staff should focus on improving the quality of medical assessments. Given that over the last two review periods and during this review, individuals reviewed generally had diagnoses justified by appropriate criteria (Round 9 – 83% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11 - 94% for Indicator 3.b), Indicator b will move to the category of requiring less oversight. The remaining indicator for this Outcome will be assessed once the	Individuals:

ISPs reviewed integrate the revised periodic assessment process.											
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	94% 17/18	2/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

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

b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that for most diagnoses reviewed clinical justification was present. The exception was for Individual #262 for whom the diagnosis of iron deficiency anemia was not clear. The etiology was unknown. Per discussion with the PCP, the diagnosis was questionable, but she continued to be treated with iron and there had been no attempts to confirm or rule out iron deficiency.

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

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
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.	33% 6/18	1/2	0/2	1/2	0/2	1/2	1/2	1/2	0/2	1/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #95 – GI problems, and constipation/bowel obstruction; Individual #262 – osteoporosis, and other: renal; Individual #217 – aspiration, and other: hypothyroidism; Individual #326 – osteoporosis, and cardiac disease; Individual #222 – aspiration, and cardiac disease; Individual #220 – seizures, and constipation/bowel obstruction; Individual #306 – osteoporosis, and other: hypothyroidism; Individual #151 – seizures, and osteoporosis; and Individual #115 – constipation/bowel obstruction, and seizures). The IHCPs that included medical plans that sufficiently addressed the individuals' chronic or at-risk conditions were those for: Individual #95 – GI problems, Individual #217 – aspiration, Individual #222 – aspiration, Individual #220 – seizures, Individual #306 – osteoporosis, and Individual #115 – seizures. b. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: It was good to see some improvement from the last review with regard to the timeliness of annual dental summaries. Improvement was needed with regard to the timeliness of dental exams. The Facility also needs to focus on the quality of dental exams and summaries.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A				N/R					
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	0% 0/8	0/1	0/1	0/1		0/1	0/1	0/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	88% 7/8	1/1	1/1	0/1		1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	25% 2/8	0/1	0/1	1/1	N/R	0/1	0/1	1/1	0/1	0/1
Comments: For Individual #326, who was in the outcome group and was at low risk for dental, some indicators were not assessed. a. In its comments on the draft report, the State disputed a number of the Monitoring Team's findings with regard to the Center's failure											

to provide timely dental examinations. The State failed to provide evidence to substantiate its disputes. For example:

- In its comments on the draft report, the State contended that because Individual #262 had an appointment for a dental exam in the future (i.e., 12/16/16), the Center's score for timeliness of a dental exam should be modified. The Monitoring Team's original finding stands.
- In its comments to the draft report, the State referenced an annual dental summary for Individual #95 to show that an exam was completed within 365 days of the previous one. Although the summary referenced a date that was within 365 days, the Center was not able to provide evidence of an actual exam on 8/4/15. In fact, when asked on site for the previous exam, the Center submitted one dated 8/18/14, which was close to two years prior to the most recent one, which occurred on 6/16/16.
- For Individual #217, the State again referenced the dental summary as evidence of timely completion of the dental examination. The Monitoring Team specifically requested in Document Request #39: "Annual dental examination, and signature (including date) page of previous dental examination…" The Center submitted the 2015 exam twice, even when asked for the previous one as part of an onsite request. The same problem was noted for Individual #306. In the future, the Center should submit documents as requested.
- Individual #220's 12/21/15 dental exam was documented as an attempt, and the assessment portion of the Dental IPN stated "unknown," but in its comments the State appeared to consider this a completed exam.
- Although Individual #151 had appointments for exams in March of 2015 and March of 2016, exams were not completed, and most of the exam report forms were blank. Both were documented as "attempts."

The Monitor changed none of these scores.

b. It was good to see that the dental exams of two individuals the Monitoring Team reviewed, both of whom were edentulous, contained all of the necessary components (i.e., Individual #326, and Individual #306). On a positive note, all dental exams reviewed included, as applicable, a description of the individual's cooperation, an oral hygiene rating completed prior to treatment, a description of sedation use, specific treatment provided, the recall frequency, and a treatment plan. Most included an oral cancer screening; information regarding the last x-ray(s) and type of x-ray, including the date; periodontal charting; a description of periodontal condition; caries risk; and periodontal risk. However, staff in the Dental Department should focus on ensuring exams include, as applicable, a summary of the number of teeth present/missing, and an odontogram (i.e., most included an odontogram that were in color, but they could not be interpreted, because there was no key to the colors). The Monitoring Team member discussed the problems noted with regard to odontograms in detail with the Dental Director during the onsite review week

c. It was positive that the dental summaries for Individual #217 and Individual #306 (who was edentulous) included all of the necessary components. It was positive that all of the remaining dental summaries included the following, as applicable:

- Effectiveness of pre-treatment sedation;
- Provision of written oral hygiene instructions;
- Dental care recommendations;
- A description of the treatment provided; and
- Treatment plan, including the recall frequency.

Most included:

- A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for

IDTs to interpret. As noted above, the Monitoring Team made the Dental Director aware of the issues noted. Moving forward, the Facility should focus on ensuring dental summaries include the following, as applicable: • Recommendations related to the need for desensitization or other plan; • Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health; and • Recommendations for the risk level for the IRRF.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
Summary: The Center's scores related to timely annual and quarterly nursing reviews decreased slightly in comparison to the two previous reviews. The remaining indicators also require continued focus to ensure nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
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.	67% 6/9	1/1	0/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	56% 5/9	1/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	22% 2/9	0/1	N/A	0/1	1/2	1/1	N/A	N/A	0/2	0/2
Comments: a. For some of the individuals reviewed, pages or components (e.g., Braden scales, weight records) of comprehensive annual reviews or quarterly reviews were missing or incomplete.											

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #95 – constipation/bowel obstruction, and weight; Individual #262 – weight, and seizures; Individual #217 – gastrointestinal (GI) problems, and infections; Individual #326 – constipation/bowel obstruction, and seizures; Individual #222 – seizures, and other: pain; Individual #220 – constipation/bowel obstruction, and seizures; Individual #306 – GI problems, and weight; Individual #151 – constipation/bowel obstruction, and seizures; and Individual #115 – constipation/bowel obstruction, and seizures].

None of the annual nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing reviews did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of comprehensive review of the status of the health risks; a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

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

- Individual #95 had unplanned weight loss reportedly due to binge eating and induced vomiting. However, nursing staff did not conduct ongoing assessments and/or make recommendations.
- Due to the lack of analysis in the annual comprehensive review, it was difficult to determine when Individual #217 had a change of status with regard to GI problems. However, in April 2016, when she had emesis, the initial nursing assessment was not complete in that it did not describe the color, odor, or amount, and did not include lung sounds (i.e., this individual has a tracheostomy). There was no abdominal assessment, no anti-reflux documentation regarding positioning, and no pain assessment.
- According to a medical IPN, dated 5/25/16, Individual #115 required a fleet's enema due to his "high impaction." Based on review of the nursing IPN of the same date, the nurse did not follow nursing guidelines for constipation in that no vital signs or lung sounds were documented, and there was no documentation of a pain assessment.
- For Individual #151 for a seizure on 2/27/16 and Individual #115 for a seizure on 3/31/16, nurses did not follow the seizure guidelines.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
Summary: Given that over the last three review periods, the Center's scores have been very low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	protocols or current standards of practice.										
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: Overall, IHCPs for the individuals reviewed did not set forth the nursing supports necessary to meet individuals' needs.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: Based on this review and the last two reviews, all of these indicators require the Center's focused attention. In addition to timely referrals to the PNMT, work is needed to ensure that PNMT reviews are complete and thorough, and that they recommend comprehensive assessments as appropriate to meet individuals' needs. When comprehensive assessments are completed, it is essential that the PNMT identify, whenever possible, the potential cause(s) of the physical and/or nutritional problem, and offer clinically justified recommendations, including, but not limited to recommendations for goals/objectives, as well as strategies to address the problem.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	33% 2/6	0/1	0/1	1/1	0/1	1/1	N/A	N/A	N/A	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	67% 4/6	1/1	0/1	1/1	0/1	1/1				1/1

c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	50% 2/4	N/A	0/1	1/1	N/A	0/1				1/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	67% 4/6	1/1	0/1	1/1	1/1	0/1				1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	17% 1/6	N/A	0/1	1/1	0/1	N/A			0/1	0/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	67% 4/6	1/1	0/1	1/1	1/1	0/1			N/A	1/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/4	0/1	0/1	N/A	0/1	0/1				N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	N/A	0/1	0/1	N/A	0/1				0/1

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

- For Individual #95, no evidence was found that the IDT made a referral, except that the PNMT meeting minutes identified the referral as occurring on 5/10/16, which was the same date as the PNMT review. This was only after she had a significant amount of unplanned weight loss, so it did not meet the criteria for within five days of the qualifying event. She lost 11 pounds from November to December 2015, with a total of 19.6-pound weight loss between November 2015 and May 2016. Finally, in May 2016, the PNMT reviewed her related to unplanned weight loss of more than 10% in six months. She weighed 155.2 pounds in January 2016; in February, March, and April, she refused to allow staff to weigh her; and then in May, a weight of 138.6 pounds was documented. The review did not determine if this weight loss was of concern (as she had been identified as overweight with a desired weight range established as 95 to 166 pounds), and the PNMT did not determine a clear etiology for the weight loss, for example, self-induced vomiting reported in the RN quarterly, binge eating, and meal refusals, etc. The PNMT review documentation did not clearly outline recommendations.
- In January 2015, Individual #262 weighed 123.4 pounds, which represented weight loss of at least 7.5% over three months, and in April 2015, she had experienced a 10% loss in six months with no evidence of referral to the PNMT at that time. Over the course of 12 months (between January 2015 and January 2016), she had a 17.5% weight loss (i.e., from 123.4 to 101.8 pounds, or 21.6 pounds), at which time the PNMT initiated a review after a hospitalization. Per the PNMT RN assessment on 1/27/16, her weight at the time of discharge from the hospital was reported to be 85.5 pounds, and her pre-hospitalization weight was 101.8 pounds. Despite noting significant weight loss, the PNMT RN did not refer Individual #262 to the PNMT. On

1/28/16, when the PNMT reviewed Individual #262, they discussed several possible causes for the weight loss, but concluded that there was no need for an assessment, because the weight loss was due to the hospitalization. However, although she did lose weight while in the hospital, significant weight loss had occurred in the year prior to her hospitalization, despite an increase in calories to 1800 per day. In February 2016, her weight was 98 pounds. In March 2016, she began a further gradual weight gain through June 2016 to 112 pounds. There was also evidence that Individual #262 had 17 falls over three months from March through June 2016, yet the IDT did not make a referral to the PNMT.

- On 10/8/15, Individual #217 was appropriately referred to the PNMT after a second respiratory event. On 10/8/15, the PNMT initiated an assessment, and on 10/22/15, completed it.
- For Individual #326, documentation was confusing. An IPN, dated 12/30/15, indicated she did not require a PNMT assessment. Yet, the PNMT RN post-hospitalization review and PNMT review were not completed until 1/14/16, even though she was discharged on 12/29/15. The RN post-hospitalization was not completed timely, and the PNMT review was incomplete.
- On 3/10/16, Individual #222 was referred to the PNMT related to aspiration, and in May 2016, he was referred again related to a choking incident. The PNMT did not initiate an assessment, and the PNMT review did not provide a clear rationale for why a comprehensive assessment was not needed. In the draft report, the Monitoring Team included the following statement: "Following a hospitalization for pneumonia In June 2016, no evidence was submitted of a PNMT RN post-hospitalization review." The State indicated he was not hospitalized for pneumonia in June 2016. In reviewing the documents, the Monitoring Team noted that the Center included two ISPAs dated June 16 and 17, 2015 in with ISPAs for the month of June 2016. The Monitor changed the score to N/A, but it remained unclear whether the Center's mistake was in dating the ISPAs incorrectly, or in including ISPAs for 2015 (which should have been purged) in with ISPAs for 2016. Regardless of which error the Center made, it made following the clinical story for Individual #222 difficult.
- For Individual #115, the IDT did not make a referral to the PNMT despite six documented falls between May 6th, and May 19th, 2016. On 5/26/16, the PNMT conducted a review, and on 6/10/16, the PNMT completed an assessment. Evidence was not found of a PNMT RN post-operative review (i.e., for the sacroplasty for sacral fracture), despite the fact that he was on the PNMT caseload at the time.

h. As discussed above, it appeared that Individual #262 and Individual #222 should have had comprehensive assessments, but did not and/or no clear rationale for not completing one was provided.

For the two individuals for whom the PNMT conducted assessments, on a positive note, the PNMT Comprehensive Assessments:

- Described the presenting problem;
- Discussed pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Reviewed applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- Reviewed, as appropriate, the individual's behaviors related to the provision of PNM supports and services;
- Provided evidence of observation of the individual's supports at his/her program areas;
- Provided an assessment of current physical status; and
- Discussed whether existing supports were effective or appropriate.

Problems with PNMT assessments varied, but in all four assessments, one or more of the following components were missing or

incomplete:

- Discussion of medications that might be pertinent to the problem, and discussion of their relevance to PNM supports and services;
- Identification of the potential causes of the individual's physical and nutritional management problems;
- Recommendations, including rationale, for physical and nutritional interventions; and
- Recommendations for measurable goals/objectives, as well as indicators and thresholds.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	56% 5/9	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: GI problems, and weight for Individual #95; falls, and weight for Individual #262; skin integrity, and aspiration/respiratory compromise for Individual #217; aspiration, and falls for Individual #326; choking, and GI problems for Individual #222; choking, and falls for Individual #220; aspiration, and falls for Individual #306; aspiration, and fractures for Individual #151; and falls, and fractures for Individual #115

a. and b., and d through f. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT

assessment/review or PNMP, including preventative physical and nutritional management interventions to minimize the individuals' risks, action steps to meet the identified objectives, clinical indicators, and/or individualized triggers and actions to take when they occur.

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs and/or Dining Plans for Individual #217, Individual #326, Individual #222, Individual #306, and Individual #151 included all of the necessary components to meet the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example, Individual #95's PNMP had not been updated since her referral to the PNMT, and did not reflect her current risk rating for weight. Individual #262's PNMP did not include the rolling walker as a piece of adaptive equipment, or show a picture of her using it. Individual #220's PNMP did not include a clear picture for positioning. The bathing section of Individual #115's PNMP did not reflect that he sits in a shower chair, nor did it mention osteoporosis with regard to handling precautions.

g. The only IHCP reviewed that defined PNMP monitoring was the one for aspiration for Individual #326.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: The Center had not made progress with these indicators.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	33% 1/3	N/A	N/A	1/1	N/A	N/A	N/A	0/1	0/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/2			N/A				0/1	0/1	

Comments: a. The IRRFs for Individual #306 and Individual #151 did not provide discussion or clinical justification for the continued medical necessity of the enteral nutrition, or discussion of the individual's potential to progress along the continuum to oral intake.

b. Although Individual #151's IDT identified that he was a candidate for less restrictive enteral nutrition, they did not detail a plan. He had recently been discharged from hospice. The IDT indicated they would monitor him for tolerance. The IDT did not provide specifics, for even, for example, when they would meet again, or for what they would monitor him to determine when steps could be taken to move in this direction.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. During the Round 9 review and this review, the Center scored at 100%, and 89%, respectively, with regard to timeliness, and 89% and 89%, respectively, with regard to completing assessments in accordance with the needs of the individuals. However, during Round 10, the Center's score was 50% for both of these indicators. The quality of these assessments was an area that continued to require improvement. The Monitoring Team will continue to review these indicators, but it was encouraging to see some progress since the last review with regard to timeliness.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
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.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	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.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of:	N/A									

	▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	N/A	0/1	N/A	0/1	N/A	N/A	0/1	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/6	0/1	N/A	0/1	N/A	0/1	0/1	N/A	0/1	0/1

Comments: a. and b. Individual #262 was readmitted to the Center after a long hospitalization. Appropriately, the OT/PT completed a comprehensive assessment.

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

- For Individual #222, the ISP meeting was held on 1/26/16, but the assessment was dated 6/17/16.

d. On a positive note, the comprehensive assessments reviewed addressed, as appropriate:

- Discussion of 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 fine, gross, sensory, and oral motor skills, and activities of daily living;
- 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
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings.

However, problems varied in the three assessments. However, in one or more, issues were noted with the following elements:

- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- As appropriate to the individual, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs,

revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

e. On a positive note, the updates reviewed included, as appropriate:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; and
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

With the remaining updates, problems varied, but issues were noted with two or more of the following elements:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings;
- 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.											
Summary: Over the last two reviews and this one, the Center's scores for these indicators varied, but were generally low. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	33% 3/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	44% 4/9	1/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1

c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	10% 1/10	0/1	0/3	0/1	0/2	N/A	0/1	N/A	1/1	0/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	17% 1/6	N/A	0/3	N/A	0/2	N/A	N/A	N/A	N/A	1/1

Comments: Based on its comments to the draft report, the State was unable to determine the concern related to Individual #115. The OT/PT assessment indicated that updates would be made to the PNMP at the time of the ISP meeting. Because no discussion was documented in the ISP document related to the PNMP, it was unclear what changes the OT/PT anticipated and/or whether the IDT discussed them.

c. and d. Examples of concerns noted included:

- For Individual #262, after an acute assessment on 1/28/16, the IDT did not hold an ISPA meeting to initiate three direct PT programs. These programs were not included in ISP action plans or an IHCP, dated 2/29/16.
- Similarly, the IDT for Individual #326 did not include two direct PT goals/objectives in an ISPA. A few months later, they were included in the ISP, but it appeared the individual was close to discharge at that time.
- Individual #220's evaluation discussed low muscle tone and loss of food from her mouth with a proposed intervention, as well as a shuffling gait. However, the IDT did not include any indirect or direct interventions in the ISP.
- Despite the fact that Individual #115 was experiencing falls and his assessment discussed motor skill deficits, the ISP did not address the need for interventions. On 6/22/16, he was referred to PT for an acute PT assessment, which was completed on 6/23/16, due to bilateral sacroplasty after having sustained sacral fractures likely the result of the traumatic fall on a wooden column in the living room of his home. This intervention was incorporated into the ISP through an ISPA.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely communication assessments/updates (Round 9 – 100%, Round 10 – 88%, and Round 11 - 88%), and the type of assessment that met their needs (Round 9 – 100%, Round 10 – 88%, and Round 11 - 88%), Indicators a and b will move to the category of requiring less oversight. Quality of the communication assessments and updates continued to be areas on which the Center needed to focus. It was encouraging to see that one of the updates reviewed included all of the necessary components, and addressed the individual's strengths, preferences, and needs. Although much more work was needed, this was	Individuals:

an improvement from the two previous reviews. All of these indicators will remain under active oversight.											
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual receives timely communication screening and/or assessment:						N/A				
	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.	88% 7/8	1/1	0/1	1/1	1/1		1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1

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

d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	0/1		N/A	N/A	N/A	N/A

e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	14% 1/7	0/1	0/1	1/1	N/A		0/1	0/1	0/1	0/1

Comments: Individual #222 communicated verbally and had no identified communication needs. Therefore, these indicators were not applicable to him.

a. and b. It was positive that for the individuals reviewed, communication assessments were completed timely, and they were the type of assessments necessary to address the individuals' needs.

d. and e. It was positive that the communication update completed for Individual #217 included the necessary components, and sufficiently addressed her strengths, needs, and preferences. Problems varied across the remaining assessments and updates, but in each two or more of the key components were insufficient to address the individual's strengths, needs, and preferences. For a majority of the assessment/updates, concerns were noted with five or more of the key components. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should focus on ensuring 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;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a 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 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.	
Summary: It was good to see improvement with regard to individuals' ISPs describing how the individual communicates. Although the ISPs of individuals reviewed generally contained strategies, interventions, and programs recommended in assessments, as discussed above, many problems were noted with assessments, and so it was not clear that ISPs contained all necessary interventions to meet individuals' needs. All of these indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
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.	75% 6/8	0/1	1/1	1/1	0/1	N/A	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	43% 3/7	1/1	1/1	0/1	0/1		N/A	1/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	89% 8/9	0/1	1/1	1/1	1/1		2/2	1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	0% 0/1	N/A	N/A	N/A	N/A		0/1	N/A	N/A	N/A
	Comments: a. For Individual #220, a direct therapy SAP was initiated on 6/20/16, but there was no evidence of an ISPA meeting at which the IDT reviewed and approved it.										

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
Summary: All individuals had at least one skill acquisition plan; they were measurable; and they were based on assessment results. Focus is needed on the SAPs being practical, functional, and meaningful, and that data are collected and shown to be reliable. The facility's director of skill acquisition and treatment reported that they were embarking on a new pilot program to improve the meaningfulness, comprehensiveness, and quality of SAP development and implementation. This was good to hear and the Monitoring Team looks forward to seeing the results of these efforts at the next review. Therefore, it makes sense for all of these indicators to remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
1	The individual has skill acquisition plans.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									
2	The SAPs are measurable.	100% 22/22	3/3	3/3	3/3	3/3	3/3	2/2	2/2	2/2	1/1
3	The individual's SAPs were based on assessment results.	95% 21/22	3/3	3/3	3/3	3/3	3/3	2/2	2/2	2/2	0/1
4	SAPs are practical, functional, and meaningful.	55% 12/22	1/3	3/3	0/3	3/3	2/3	2/2	1/2	0/2	0/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	18% 4/22	1/3	1/3	0/3	1/3	0/3	0/2	0/2	1/2	0/1

Comments:
1. All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. There were only two SAPs available to review for Individual #214, Individual #84, and Individual #199. Additionally, there was only one SAP available for Individual #187, for a total of 22 SAPs for this review.

2. All of the SAPs were measurable.

3. Ninety-five percent of the SAPs were based on assessment results. The exception was Individual #187's purchasing SAP, which his FSA suggested was a skill he already possessed.

4. Several SAPs were judged not to be practical or functional because they represented a compliance issue rather than a new skill (e.g., Individual #199's swab his mouth SAP).

5. The majority of SAPs did not have interobserver agreement (IOA) demonstrating that the data were reliable. The exception was Individual #262's operate her audio device SAP, which had IOA above 80% and was assessed in the last six months. Additionally, the Monitoring Team observed Individual #199's play loteria, Individual #290's imitate signs, Individual #109's wash clothes, and Individual #262's operate audio device SAPs, and found that they were scored accurately. The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data). It is recommended that San Antonio SSLC establish the demonstration of reliable SAP data as a priority.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.											
Summary: Indicators 10 and 11 improved since the last review, and indicator 12 was slightly lower, but still at a high level. With sustained performance, indicators 10 and 12 may move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187

10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	33% 3/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:
10-12. All individuals had current FSAs, PSIs, and vocational assessments (if appropriate). Several individual's PSIs (e.g., Individual #199's) were not, however, available to the IDT at least 10 days prior to their ISP. It was encouraging to see that 89% of individual's FSAs and vocational assessments included recommendations for SAPs. The exception was Individual #187's vocational assessment.

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

This Domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Ten of these indicators, in restraints, psychiatry, medical, dental, and OT/PT, had sustained high performance scores and will be moved the category of requiring less oversight. No outcomes will move entirely to less oversight.

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

Goals/Objectives and Review of Progress

Variables that were identified as potentially playing a role in the occurrence of behaviors that often led to more than three restraints in any rolling 30-day period were identified, which was good to see, however, actions to address these variables were not taken.

Without psychiatry-related measurable goals and objectives, progress could not be determined. Psychiatry clinic was observed for four individuals. The various criteria for this indicator were met, however, although data were provided and available, they were not specifically utilized in decision making for medication adjustments.

For behavioral health services, San Antonio SSLC had good reliable data for eight of the individuals. This was good to see and one of the individuals was rated as making progress. Behavioral health services' peer review was up and running and had been for some time now.

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Acute Illnesses/Occurrences

With regard to acute illnesses/occurrences, improvement was needed with regard to nursing staff's assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis until the issue resolved; timely notification of the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification; the development of acute care plans for all relevant acute care needs; and development of acute care plans that are consistent with the current generally accepted standards.

Overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Facility and/or in other settings varied, and for a number of individuals reviewed, significant concerns were noted. On a positive note, over the last two review periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse generally communicated necessary clinical information with hospital staff. As a result, the related indicator will move to the category of requiring less oversight.

Despite the absence of measurable goals, it was apparent that when some (but not all) individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments, suggestions for non-pharmacologic approaches) were developed and implemented. Interim psychiatric clinics were held for some, but not all, of the individuals, when needed.

Implementation of Plans

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

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

For a number of the consultations reviewed, problems were noted with regard to the PCPs reviewing consultations and indicating agreement or disagreement, doing so in a timely manner, and writing an IPN that included necessary components. The Center also needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs, including the clinical justification for their decisions.

The Center also needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Problems were noted for the individuals' reviewed with regard to dental care and treatment. The Center should focus on ensuring individuals receive necessary prophylactic dental care, x-rays, fluoride treatment as appropriate, treatment for periodontal disease, and timely restorations, and that at preventative visits, Dental Department staff provide tooth-brushing instruction to individuals and/or their staff. In comparison to the last two reviews, it was good to see some improvement with regard to the dentist's assessment of the need for dentures for individuals with missing teeth.

Overall, IDTs were not identifying and responding to individuals' changes in healthcare status in a timely and thorough manner. For the individuals reviewed, numerous examples were found of individuals experiencing issues with regard to weight loss, falls, and swallowing issues for whom delays in the IDTs' responses, as well as problems with the thoroughness of the response resulted in individuals' needs not being met.

With regard to Quarterly Drug Regimen Reviews (QDRRs), for a number of individuals reviewed, labs were not up-to-date, or showed results that raised concerns. However, these individuals' QDRRs did not make corresponding findings and/or recommendations. It was good to see that prescribers reviewed QDRRs timely, and documented agreement or provided a clinical justification for lack of agreement with Pharmacy's recommendations. When prescribers agreed to recommendations for the individuals reviewed, they generally implemented them.

Adaptive equipment was generally clean and in good working order. The two related indicators will move to the category of requiring less oversight. Proper fit was sometimes still an issue.

Although there was some improvement from previous reviews, there were still many instances (close to 36% of 70 observations) in which staff were not implementing individuals' PNMPs or Dining Plans, or were implementing them incorrectly. PNMPs and Dining Plans are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of them is non-negotiable. The Center should continue to determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Some individuals were overdue for quarterly psychiatry clinics. Some individuals were overdue for neurology-psychiatry consultations.

Five progress notes included actions to address their lack of behavioral progress. Actions suggested to address lack of progress were implemented. The majority of staff were trained, summaries for float staff existed in all cases, and the facility had a team of certified behavior analysts (BCBAs) who wrote and oversaw PBSPs.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
Summary: Variables that were identified as potentially playing a role in the occurrence of behaviors that often led to restraint were identified, which was good to see, however, actions to address these variables were not taken (indicators 20, 21, 22). Given the importance of this activity for the protection of individuals who have frequent restraint occurrences, this set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	214								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 1/1	1/1								
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 1/1	1/1								
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/1	0/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/1	0/1								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/1	0/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint,	100% 1/1	1/1								

	2. and if any were hypothesized to be relevant, a plan to address them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 1/1	1/1								
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 1/1	1/1								
26	The PBSP was complete.	N/A	N/A								
27	The crisis intervention plan was complete.	100% 1/1	1/1								
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 1/1	1/1								
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 1/1	1/1								

Comments:
18-29. This outcome and its indicators applied to Individual #214.

18. ISPAs to address more than three restraints in 30 days should occur within 10 business days of the fourth restraint. Individual #214 had his fourth restraint in 30 days on 3/17/16, and his ISPA met on 3/28/16 to address these restraints.

20. Individual #214's ISPA following more than three restraints in 30 days had minutes reflecting a discussion of psychiatric issues that potentially contributed to his restraints, however, the minutes did not reflect any actions (e.g., schedule a psychiatry clinic, etc.) to address this potential contributing variable.

21. Individual #214's lack of structure in the residence and day setting was discussed in his ISPA as contributing to his restraints, however, no documentation of an action plan (e.g., schedule additional activities, enhance active treatment, etc.) to address the lack of structure was evident.

22. Individual #214's ISPA minutes included a discussion of a potential antecedent condition that was hypothesized to contribute to his restraints (i.e., increased demands), however, no actions (e.g., establishing and reinforcing an alternative behavior to escape/avoid demands, etc.) to address that antecedent were documented in the ISPA.

23. Individual #214's ISPA minutes reflected a discussion among the IDT hypothesizing that receiving emergency medication via a shot was maintaining some aggression that provoked restraints. The team suggested the use of a different vehicle for administering the medication to address that potential maintaining variable.

29. Individual #214's ISPAs indicated that his IDT reviewed his PBSP, and found it to be complete.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: San Antonio SSLC routinely conducted Reiss screens for all individuals and had been doing so for a number of years. Therefore, indicator 1 will move to the category of requiring less restraints. Indicators 2 and 3 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	217	115	151	326						
1	If not receiving psychiatric services, a Reiss was conducted.	100% 4/4	1/1	1/1	1/1	1/1						
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A	N/A						
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A	N/A						
Comments: 1. Of the 16 individuals reviewed by both Monitoring Teams, four individuals were not receiving psychiatric services. All four of these individuals were assessed utilizing the Reiss screen. Unfortunately, none of these assessments were dated, so it was not possible to determine if these were initial screening assessments or if they were performed as a result of a change in status.												

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.												
Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledged that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for some (though not all) individuals. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	78% 7/9	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1

11	Activity and/or revisions to treatment were implemented.	67% 6/9	1/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1

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

10-11. Despite the absence of measurable goals, it was apparent that when some individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments, suggestions for non-pharmacologic approaches) were developed and implemented. There was an example where revisions to treatment were discussed, but not specifically recommended or implemented. It was documented in the most recent psychiatric clinic for Individual #95, 3/9/16, that behavioral management should be the main therapeutic approach. Although there was documentation of Individual #95 experiencing increasing difficulties including three chemical restraints (4/29/16, 4/30/16, 5/15/16), the behavioral support plan was last updated in October 2015.

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

Summary: Performance on these two indicators was low at this review and at the last two reviews, too. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	290	95	262	41	214	84	199	187
23	Psychiatric documentation references the behavioral health target behaviors, <u>and</u> the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	The psychiatrist participated in the development of the PBSP.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1

Comments:
23. While the target behaviors (e.g., behavioral challenges) identified for monitoring were consistent, what was lacking was how these behaviors related to the specific psychiatric diagnosis.

24. In the cases of Individual #84 and Individual #95, the psychiatrist referenced the PBSP in quarterly clinical documentation. Other than that, there was no evidence of psychiatrist participation in development of the PBSP.

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

Summary: Performance on these three indicators was low at this review and at the last two reviews, too. These indicators will remain in active monitoring. That being said, criteria were met for all three indicators for two individuals, thus, demonstrating that the facility has the ability to do so for all individuals.	Individuals:

#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	60% 3/5	1/1	0/1	N/A	1/1	N/A	N/A	0/1	N/A	1/1
26	Frequency was at least annual.	50% 2/4	N/A	0/1	N/A	1/1	N/A	N/A	0/1	N/A	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	40% 2/5	0/1	0/1	N/A	1/1	N/A	N/A	0/1	N/A	1/1

Comments:
25-27. This outcome addresses the coordination between psychiatry and neurology. These indicators applied to five of the individuals. Individual #290 and Individual #84 were overdue for neurology follow-up. Individual #290 was last seen in neurology clinic February 2015; Individual #84 was last seen in neurology clinic in 2014. Individual #199 was last seen in June 2015 and was currently due for annual review.

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

Summary: San Antonio SSLC was not able to provide regularly occurring quarterly psychiatric reviews to all individuals, nor did the content of the quarterly review documentation meet criteria. One aspect of the psychiatry clinics did not occur, resulting in indicator 35 receiving 0 scores, a decrease since the last review. Turnover in psychiatric providers at the facility likely contributed to the inability to meet these indicators. All three will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
33	Quarterly reviews were completed quarterly.	63% 5/8	N/A	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	0% 0/4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
33. There were three individuals who were overdue for quarterly psychiatric clinic: Individual #290, Individual #95, and Individual #41.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing two to four components; most commonly, a review of the implementation of non-pharmacological interventions, and the description of symptoms that support the psychiatric diagnosis. In six examples, data were not documented as presented, reviewed, or utilized in the decision-

making process regarding psychotropic medication adjustments.

35. Psychiatry clinic was observed for four individuals, although these individuals were not part of the group reviewed by the Monitoring Team (Individual #209, Individual #246, Individual #7, Individual #154). In all of these examples, criteria for this indicator were met except regarding there being plans for medication and other treatment being based on data. Data were provided, but they were not specifically utilized in decision making for medication adjustments.

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

Summary: The facility showed continued improvement across this review and the last two reviews. More work, however, was needed. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	290	95	262	41	214	84	199	187
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1

Comments:
36. Assessments were generally occurring in a timely manner. Most cases met criteria, but in two cases, although the psychiatrist reviewed the document within the allotted time, the PCP review was delayed for as much as three months.

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

Summary: For this review and the last review, these indicators, regarding interim types of psychiatry clinics, occurred about half of the time. In the February 2015 review, these indicators scored at 100%. Likely, the turnover in psychiatry staff at the facility contributed to there being challenges in seeing individuals in between regularly scheduled quarterly reviews. All three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	290	95	262	41	214	84	199	187
37	Emergency/urgent and follow-up/interim clinics were available if needed.	57% 4/7	1/1	0/1	0/1	N/A	1/1	0/1	1/1	1/1	N/A
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	57% 4/7	1/1	0/1	0/1	N/A	1/1	0/1	1/1	1/1	N/A
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	57% 4/7	1/1	0/1	0/1	N/A	1/1	0/1	1/1	1/1	N/A

Comments:
37-39. For four individuals, all criteria were met. In three cases (Individual #290, Individual #95, Individual #214), there was

documentation that the individual had experienced either physical restraint, chemical restraint, or PEMA. In all three of these cases, an emergency or urgent clinic should have occurred.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These important indicators maintained performance over the past two reviews. Better documentation (e.g., in psychiatric annual updates and quarterly reviews, as noted in those related indicators in this report) and improvements in the work of the polypharmacy committee may result in improved scores for these indicators. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	0% 0/3	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A	0/1
Comments: 40-41. In the case of Individual #199, there was cause for concern because he was prescribed Zyprexa 40 mg daily, which is double the recommended daily dosage. Individual #214 was prescribed seven psychotropic medications, three of which were atypical antipsychotics. 42. A PSP was recommended for Individual #262, but had not yet been implemented. 43. Individual #95, Individual #214, and Individual #199 were administered PEMA. Review of the documentation revealed that these events would be more appropriately classified as chemical restraint. The facility reported that they stopped using PEMA as of 4/27/16.											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.	
Summary: As discussed at length while onsite, it was good to see that the facility re-instituted polypharmacy (it was not occurring at the time of the last review), however, more work was needed to meet the requirements of these indicators, all of which will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	20% 1/5	0/1	N/A	1/1	N/A	N/A	0/1	0/1	0/1	N/A
45	There is a tapering plan, or rationale for why not.	80% 4/5	1/1	N/A	1/1	N/A	N/A	0/1	1/1	1/1	N/A
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.	60% 3/5	1/1	N/A	1/1	N/A	N/A	1/1	0/1	0/1	N/A
Comments: 44-45. These indicators applied to five individuals. Polypharmacy justification was appropriately documented in one case. 46. It was good to see that San Antonio SSLC had re-started polypharmacy committee meetings. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for three of these nine individuals, that is, they met criteria for polypharmacy. There were, however, no detailed notes regarding the review. As discussed at length during the onsite monitoring visit, there was need for improvement in polypharmacy committee to ensure a critical review of medication regimens that met criteria for polypharmacy.											

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: San Antonio SSLC had good reliable data for eight of the individuals. This was good to see and one of the individuals was rated as making progress. For the most part, the facility identified corrective actions and implemented them. This set of indicators will remain in active monitoring. With sustained performance, indicator 9 might move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
6	The individual is making expected progress	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	71% 5/7	1/1	1/1	1/1	1/1	0/1	N/A	0/1	1/1	N/A

9	Activity and/or revisions to treatment were implemented.	100% 5/5	1/1	1/1	1/1	1/1	N/A	N/A	N/A	1/1	N/A

Comments:
6. Individual #187 was scored as making progress. Individual #214 was also making progress, however, the data were not demonstrated to be reliable (see indicator #5), so he was not scored as progressing. The remaining individuals were not making progress.

8. Individual #109, Individual #290, Individual #95, Individual #199, and Individual #262's progress notes included actions to address their lack of behavioral progress. For example, Individual #199's progress note suggested retraining staff to improve compliance with his PBSP. Individual #41 and Individual #84's progress notes, however, did not include action to address the lack of progress.

9. There was evidence that the actions suggested to address Individual #109, Individual #290, Individual #95, Individual #199, and Individual #262's lack of progress were implemented.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.

Summary: Documentation of training of staff greatly improved compared to the two previous reviews. This was good to see. Continued focus will be required. The other two indicators in this outcome, regarding a PBSP summary and the qualifications of behavioral specialists were at 100% for this and the previous two reviews. These indicators, 17 and 18, will be moved to the category of requiring less oversight. Indicator 16 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	62% 5/8	1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	N/A
17	There was a PBSP summary for float staff.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A

Comments:
16. It was encouraging to see that the majority of individuals had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing their PBSPs were trained on the its implementation. Individual #262, Individual #41, and Individual #214 were the exceptions.

17. All of the individuals had evidence of an abbreviated PBSP for float staff to review.

18. All individuals' functional assessments and PBSPs were written by a behavioral specialist who was enrolled in, or had completed BCBA coursework. Additionally, all functional assessments and PBSPs were signed off by a BCBA.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: PBSPs and individuals' status and progress were reviewed regularly. In fact, four of the five indicators in this outcome scored at 100% for this review and also for the previous two reviews. These will be moved to the category of requiring less oversight (indicators 19, 21, 22, 23). In addition to maintaining this level of review, the facility should focus upon the requirements for indicator 20, that is, to ensure that the graphs of individuals' behavioral disorders and replacement behaviors are useful, clear to the reader, and regularly updated. Indicator 20 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
19	The individual's progress note comments on the progress of the individual.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
20	The graphs are useful for making data based treatment decisions.	50% 4/8	1/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	N/A
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

Comments:

19. All individuals had progress notes that commented on the individual's progress.

20. All progress notes had graphs. Individual #109, Individual #290, Individual #95, and Individual #262's graphs were judged to encourage data based decisions by including indications of the occurrence of important environmental changes (e.g., medication changes) and clearly indicating trends. The usefulness of Individual #41, Individual #214, Individual #84, and Individual #199's graphs, however, were limited because they included multiple data paths that obscured the visual observation of trends.

21. None of the individuals reviewed had psychiatric clinic meetings during the onsite review. In order to score this indicator, the

Monitoring Team observed Individual #209's psychiatric clinic meeting. Current data were presented and graphed, which encouraged data based decisions by the team.

22. The minutes from Individual #199's February 2016 peer review suggested the use of blocking to prevent injury during changing routines. This procedure was included in his subsequent PBSP.

23. None of the individuals had a peer review meeting during the onsite review. In order to score this indicator, the Monitoring Team observed Individual #332's peer review. Individual #332 was reviewed because she had not been progressing as expected. Her peer review included the review of her functional assessment, PBSP, and progress notes. There was participation and discussion by the behavioral health services team to improve her PBSP. Additionally, San Antonio SSLC had documentation that internal peer review meetings were consistently occurring weekly, and external peer review meetings were occurring monthly.

Outcome 8 – Data are collected correctly and reliably.											
Summary: The behavioral health data collection systems at San Antonio met the many criteria required by indicators 26 and 27 for this review and the previous two reviews, too. However, given the upcoming changes with the state's electronic health record, the Monitoring Team will monitor these indicators at the next review, too. In addition, although the facility had established acceptable measures of the three types of quality assurances, goals were not yet established or met.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A

Comments:

26-27. The data collection system for target and replacement behaviors, was individualized, flexible, and extended to all treatment settings at San Antonio SSLC.

28. There were established measures of IOA, data collection timeliness, and treatment integrity.

29. There were not established frequency and minimal levels of IOA, data collection timeliness, and treatment integrity for any of the individual's PBSP data. 30. All of the individuals had IOA, data collection timeliness, and treatment integrity, however, goal frequencies of collection, and minimal acceptable levels, were not established, so this indicator was scored 0. It is suggested that the establishment of frequency and minimal levels of IOA, data collection timeliness, and treatment integrity be a priority for the behavioral health department.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	22% 4/18	0/2	1/2	1/2	0/2	0/2	0/2	1/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review [i.e., Individual #95 – gastrointestinal (GI) problems, and constipation/bowel obstruction; Individual #262 – osteoporosis, and other: renal; Individual #217 – aspiration, and other: hypothyroidism; Individual #326 – osteoporosis, and cardiac disease; Individual #222 – aspiration, and cardiac disease; Individual #220 – seizures, and constipation/bowel obstruction; Individual #306 – osteoporosis, and other: hypothyroidism; Individual #151 – seizures, and osteoporosis; and Individual #115 – constipation/bowel obstruction, and seizures]. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #262 – other: renal, Individual #217 – aspiration, Individual #306 – osteoporosis, and Individual #151 – seizures.											

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

Outcome 4 – Individuals receive preventative care.

Summary: Two of the nine individuals reviewed received the preventative care they needed. The overall percentages have fluctuated for the last two reviews and this one. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's scores improve and the Center's quality assurance/improvement mechanisms related to preventative care can be assessed. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Individuals:

#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	60% 3/5	N/A	0/1	N/A	0/1	N/A	N/A	1/1	1/1	1/1
	iii. Breast cancer screening	20% 1/5	N/A	0/1	0/1	1/1	N/A	0/1	0/1	N/A	N/A
	iv. Vision screen	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	38% 3/8	1/1	0/1	0/1	0/1	N/A	0/1	1/1	0/1	1/1
	vii. Cervical cancer screening	40% 2/5	0/1	0/1	1/1	N/A	N/A	0/1	1/1	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.										

Comments: a. The following are examples of problems that were noted:

- In responding to the Monitoring Team's document request for Individual #95, the Center included the statement: "IDT met and decided to use sedation when attempting OB/GYN pap but due to possible misconduct, sedation is questionable for any action performed below the waist." The Center indicated that the PCP and IDT were addressing it, but there was no explanation in the AMA, only that the individual refused.
- For Individual #262, no colonoscopy was completed, even though the individual continued to be treated for iron deficiency anemia. The PCP documented in the AMA that the hemoglobin had dropped and the "anemia now is a little low for the degree of CKD [chronic kidney disease]." In addition, the request for DEXA scan results indicated: "no data to submit," but the individual had a diagnosis of osteopenia and was rated at high risk. No mammogram report was submitted. The AMA stated the study was completed on 7/21/15. However, the nursing assessment, dated 9/17/15, documented that the mammogram was not completed. The Preventative Care Flow Sheet documented that a mammogram was completed in 2013. The response to the document request noted: "This individual is to be scheduled in July 2016 for mammogram." No pap smear was completed, as the individual was described as combative and aggressive. Electrocardiograms (EKGs) for medication monitoring were not timely (i.e., 12/4/14 and 2/2016). The computer interpretation was abnormal EKG. The PCP did not review the document (i.e., no initials or over-read on the copy submitted from the record).
- For Individual #217, a DEXA was noted as not applicable. The individual had a Vitamin D deficiency that had been treated, but she remained with suboptimal Vitamin D serum levels.
- Individual #326 was prescribed medication for osteoporosis, but the last DEXA was in 2012. She had no history of having a colonoscopy, and was now reportedly exempt due to being 76 years old. She had a history of frank rectal bleeding in 2012 with undetermined cause.
- For Individual #220, the AMA indicated a pap smear was completed in 2015, but no documentation of this was submitted. The response to the document request indicated mammograms, DEXA scans, and cervical cancer screening were discontinued for her "per the decision of the IDT." No rationale was provided.

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

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will continue under active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A

Comments: Individual #151's DNR Order had been in place since 2009 with the "qualifying conditions" listed as recurrent aspiration pneumonia, and bradycardia due to autonomic dysfunction. IDT and/or Ethics Committee review was necessary.

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

Summary: Given that over the last two review periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse generally communicated necessary clinical information with hospital staff (Round 9 – 100% for Indicator 4.f, Round 10 – 100% for Indicator 4.f, and Round 11 -83% for Indicator 6.f), Indicator f will move to the category of requiring less oversight. However, overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Facility and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. The Monitoring Team will continue to review the remaining indicators.

#	Indicator	Overall Score	Individuals: 95	262	217	326	222	220	306	151	115
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.	22% 2/9	0/2	0/1	0/1	0/1	N/A	N/A	N/A	1/2	1/2
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.	11% 1/9	0/2	0/1	0/1	0/1				0/2	1/2
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	50% 3/6	N/A	1/1	N/A	1/2	N/A	0/1	N/A	0/1	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 2/4		0/1		2/2		0/1		N/A	N/A
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	83% 5/6		1/1		2/2		0/1		1/1	1/1
f.	If individual is transferred to the hospital, PCP or nurse	83%		1/1		2/2		0/1		1/1	1/1

	communicates necessary clinical information with hospital staff.	5/6									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	60% 3/5		0/1		2/2		0/1		N/A	1/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	33% 2/6		0/1		1/2		0/1		1/1	0/1

Comments: a. and b. For six of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed nine acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #95 (human bite requiring antibiotics on 2/23/16, and head trauma/laceration on 3/23/16), Individual #262 (cellulitis of temple on 6/3/16), Individual #217 (emesis on 4/10/16), Individual #326 (seizures on 1/22/16), Individual #151 (viral sinusitis on 3/5/16, and blepharitis on 5/13/16), and Individual #115 (tinea corporis on 1/12/16, and fall on 5/20/16).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #151 (viral sinusitis on 3/5/16), and Individual #115 (fall on 5/20/16).

The acute occurrence reviewed for which follow-up was needed, and documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized included the fall for Individual #115 5/20/16.

The following provide examples of concerns noted:

- Per nursing documentation, on 2/16/16, Individual #95 sustained a human bite wound to her left hand. On 2/21/16, nursing staff documented follow-up. The first and only PCP note related to this was on 2/23/16. The assessment resulted in a diagnosis of human bite wound with cellulitis. Antibiotics were prescribed. There was no PCP follow-up for the diagnosis of cellulitis. The next PCP note was on 3/23/16.
- On 3/23/16, the PCP documented that Individual #95 sustained a laceration to the head after a privacy screen hit her on the head. Neurological checks had been implemented, but the PCP did not document an adequate neurological exam. A non-bleeding laceration that did not require closure was noted. The plan was to monitor for infection. However, there was no follow-up documented in the record. The next PCP note was dated 6/28/16, and it was related to an ED visit.
- For Individual #262's cellulitis of the temple on 6/3/16, a medical provider gave a verbal order for the individual to start on antibiotics. There was no documentation of a medical assessment. The diagnosis of cellulitis appeared to be based on a nursing assessment and not a medical evaluation by a primary care provider.
- Based on nursing documentation, between 4/10/16 and 4/23/16, Individual #217 had seven episodes of emesis. In May and June, several other episodes of emesis were documented. No physician assessment was documented in the records. In fact, from 12/1/15 through the June document request, no physician assessments were documented in the IPNs other than the February 2016 AMA. Three consult forms, which were not complete, were present in the record and three quarterly medical assessments were submitted. However, no evidence was presented to show that the PCP had any contact with the individual

during this six-month period other than to complete the AMA.

- On 1/21/16, Individual # 326 had multiple seizures. Nursing staff documented seizures lasting two minutes, 12 minutes, and 14 minutes over a period of a few hours. Versed 5 milligrams (mg) intramuscular (IM) was administered with the second seizure. The PCP was notified. It was not clear how the decision was made to administer IM Versed without an immediate transfer to a higher level of care. This individual experienced status epilepticus with a documented 12-minute seizure. This is a life-threatening emergency that requires assessment and treatment in an acute care facility. The individual was transferred only after the 14-minute seizure occurred. Upon return from the hospital, on 1/22/16, the PCP saw her. The next evaluation was six days later, on 1/28/16. A history of status epilepticus should have resulted the PCP conducting closer follow-up.
- On 5/13/16, the PCP documented Individual #151 had a history of eye injury and had discharge following trauma. The diagnosis was traumatic blepharitis and the treatment was artificial tears. The timing of the injury was not clear. In the documents provided, there was no previous medical assessment related to eye trauma/injury. On 4/12/16, a nursing IPN noted a possible injury to the right eye with dried blood. There was no further documentation related to this possible injury.
- On 1/12/16, the PCP documented that staff reported a rash on the buttocks of Individual #115. The diagnosis was tinea corporis, and the PCP ordered a four-week course of griseofulvin. The plan was to follow-up in 10 days, but there was no documentation of a follow-up medical evaluation. Oral antifungals, such as griseofulvin, are indicated for severe cases of tinea corporis. It would appear that the decision to use oral agents over topical agents would indicate that the dermatitis was severe enough to warrant use, and, therefore, require medical follow-up.

For five of the nine individuals reviewed, the Monitoring Team reviewed six acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #262 (laminectomy on 12/21/16), Individual #326 (subdural hematoma on 12/21/15, and pneumonia on 3/15/16), Individual #220 (metacarpal fracture on 5/21/16), Individual #151 (G-Tube change on 12/12/15), and Individual #115 (laceration on 6/1/16).

c. through h. The following provide examples regarding acute illnesses/occurrences requiring hospital admission or ED visit:

- On 12/7/15, the PCP documented that Individual #262 was being sent to the ED for evaluation of altered gait (documented for several days). Consideration was given to drug toxicity in light of the severe kidney disease. The individual returned after having a normal head computed tomography (CT) scan. It was noted that the case would be discussed with the PCP and a neurological evaluation would occur. On 12/11/15, the Medical Director documented that he was asked to see the individual in follow-up to the PCP's initial evaluation for changes in ability to ambulate. Staff reported that the individual was drifting to the left and favoring her right side. The diagnosis was ataxia, rule out musculoskeletal cause. Labs were ordered along with x-rays of the ankle, hip, and pelvis. A neurological consult was scheduled for the following week. There was no follow-up note to document the results of the x-rays and labs. On 12/18/15, the PCP documented the individual continued to have ataxic gait during the day, and the camera video showed little or no ataxia at night. The consensus was to taper the Risperidone.

  On 12/19/15, the individual was sent to the ED after falling, and being unable to get up or grip with the left had. She returned from the ED at 2:50 p.m., and the PCP was notified. On 12/20/15, the individual was sent to the ED again due to generalized weakness, tiredness, and a laceration to the forehead. The PCP documented a post-ED note at 5:00 p.m. noting that a stat Ear, Nose, and Throat (ENT) consult was requested for a cerumen impaction. On 12/21/15, at 4:30 p.m., the individual transferred to the ED again for further deterioration of neurological status. There was no PCP evaluation prior to the transfer.

On 12/22/15, the PCP documented that a further deterioration of neurologic status was noted, and that the individual was being referred back for evaluation (this appeared to be a late entry for the transfer that occurred the previous day). Individual #262 was admitted to the hospital where she was documented to have severe cervical spine stenosis with evidence of spinal cord compression. She underwent a posterior spinal fusion and laminectomy. Post-operatively, she had poor strength in her arms and legs greater on the lower left extremity. On 1/27/16, she returned to the Center, and on 1/28/16, the PCP saw her. The PCP did not document any further follow-up until 3/7/16. This assessment was related to picking facial lesions.

In summary, this problem was not acute and worsened over a two-week period prior to the final transfer. The individual had multiple trips to the ED, and the neurologist saw her, but none of the clinicians detected the deficits that were occurring. It is important to note that the only medical exam that documented a reasonable neurological evaluation was the one the Medical Director completed on 12/11/15. Even so, the providers did not document in subsequent notes the results of the studies that he ordered.

- On 11/28/15, nursing staff documented that Individual #326 fell and hit her head on the door. There was no documentation of PCP notification, but nursing staff initiated neurological checks. On 12/13/15, nursing staff documented that the individual sustained a contused forehead after another fall. The PCP documented an assessment with a diagnosis of left brow hematoma. This assessment was not adequate to address the evidence of a neurological impairment with foot dragging and weakness. The plan was to use ice packs and monitor. On 12/14/15, the Medical Director documented an assessment related to a "mechanical fall." On 12/18/15, the PCP noted that the individual was being assessed for dragging her left foot and quadriceps weakness. PT was to follow. On 12/21/15, the PCP conducted an assessment and documented that the individual was not communicative and was unable to walk. She was referred to the ED for a decreased level of consciousness and leaning to the left. Once she became unresponsive, Center staff promptly transferred her to the hospital. The individual was admitted.

  According to the hospital summary, on 12/12/15, Individual #326 hit her head. "Initially, the individual was ok but had insidious decline over the past week. This am slumped to the left in her wheelchair, minimally responsive. Became combative and had a glascow coma scale of 6 upon arrival. Intubated to protect airway." The individual underwent a craniotomy with evacuation of a subdural hematoma with partial restoration of left-sided strength and mental status. On 12/29/15, she returned to the Center and the PCP evaluated her. On 12/30/15, the PCP noted she was seen at follow-up and the PCP reviewed the ISPA. Labs were to be checked. There was no additional PCP documentation. As a result, it appeared there was no additional follow-up for an individual who underwent a craniotomy for evacuation of a subdural hematoma. Additionally, the PCP did not document the labs that were ordered upon her return. On 1/4/16, the individual was transferred to a rehabilitation facility. There was no physician documentation related to this transfer. On 1/8/16, the rehabilitation facility discharged the individual due to "no progression." On 1/8/16, the PCP documented that the individual had rapidly reached her rehabilitation potential and her prognosis was guarded.

- On 5/21/16, at 8 a.m., nursing documented that Individual #220's right hand was swollen and bruised. The PCP was contacted. Per nursing, "MD stated 'no x-ray at this time; it is a discovered injury.'" At 5:00 p.m., the PCP noted that the individual had a swollen hand of unknown duration and was being referred to the ED. On 5/22/16 at 5:00 p.m., the PCP noted the individual

had a fracture of the right third and fourth metacarpals, the hand was immobilized, and the individual would follow-up with orthopedics. This was the final PCP IPN entry. There was no discussion of the orthopedic consult, recommendations, or follow-up from the PCP.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: Given that over the last two review periods and during this review, for a number of the consultations reviewed, problems were noted with regard to the PCPs reviewing consultations and indicating agreement or disagreement, doing so in a timely manner, and writing an IPN that includes necessary components, all of these indicators will remain in active oversight. The Center also needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs, including the clinical justification for their decisions.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	65% 11/17	2/2	0/2	0/2	2/2	2/2	1/2	0/1	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	71% 12/17	2/2	0/2	1/2	2/2	2/2	1/2	0/1	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	65% 11/17	2/2	0/2	0/1	2/2	2/2	1/2	0/1	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	89% 8/9	2/2	N/A	N/A	2/2	2/2	N/A	N/A	2/2	0/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/3	N/A	0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1
Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #95 for vision on 12/4/15, and audiology on 12/30/15; Individual #262 for nephrology on 3/30/16, and orthopedics on 3/23/16; Individual #217 for vision on 5/26/16, and audiology on 1/13/16; Individual #326 for vision clinic on 5/17/16, and pulmonary on 3/22/16; Individual #222 for audiology clinic on 12/9/15, and podiatry on 5/6/16; Individual #220 for audiology on 2/17/16, and neurology of 4/1/16; Individual #306 for audiology on 12/9/15; Individual #151 for vision on 3/15/16, and audiology on 3/23/16; and Individual #115 for neurology on 3/8/16, and eye clinic on 5/17/16. c. At times, the Center did not provide IPNs related to the consultation, or provided IPNs that were not in the active record. Other PCP											

IPNs related to the consultations reviewed did not include all of the components State Office policy requires.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, for all except the consultation for Individual #115 for neurology on 3/8/16. This is discussed in further detail below. It should be noted, however, that agreement or disagreement could not be determined for all of the applicable consultations.

e. For Individual #262 for nephrology on 3/30/16, the consult stated: "Due to her inability to cooperate, future dialysis will not be possible." There was no IPN entry acknowledging these findings and no discussion of this was referred to the IDT.

For Individual #115 for neurology on 3/8/16, the epileptologist noted the assessment of epilepsy in a patient with orthostasis, and advised to obtain a holter monitor and consider a trial of florinef. The PCP agreed with this plan, and at that time, it was not referred to the IDT for discussion. However, the recommendations were not implemented. On 5/26/16, the PCP documented that the IDT rejected the recommendations as not necessary. However, there was no medical explanation/rationale for the disagreement.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
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.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #95 – GI problems, and constipation/bowel obstruction; Individual #262 – osteoporosis, and other: renal; Individual #217 – aspiration, and other: hypothyroidism; Individual #326 – osteoporosis, and cardiac disease; Individual #222 – aspiration, and cardiac disease; Individual #220 – seizures, and constipation/bowel obstruction; Individual #306 – osteoporosis, and other: hypothyroidism; Individual #151 – seizures, and osteoporosis; and Individual #115 – constipation/bowel obstruction, and seizures).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnosis and/or at-risk condition: Individual #306 – osteoporosis. The following provide examples of concerns noted regarding medical assessment, tests, and evaluations:

- For Individual #95, the AMA stated that gastroesophageal reflux disease (GERD) was controlled with medication and medication would continue. The plan did not discuss other non-pharmacologic reflux measures (GERD precautions). The

individual's diet was normal, but the AMA did not comment on specific foods/liquids that should be avoided as part of GERD management. The IHCP noted that GERD precautions should be followed per the PNMP. However, it failed to provide any information on the avoidance of reflux provoking foods.

- In addition, Individual #95's AMA indicated constipation was controlled with stimulant laxatives and rescue medications. There was no discussion in the AMA or the IRRF/IHCP regarding lifestyle modifications (activity), dietary modifications (fiber, fruits, water, etc.) and other non-pharmacologic interventions. This individual remained at risk due to a moderate anticholinergic burden. Nursing staff documented the use of rescue medications.
- The Assessment and Plan section of Individual #262's AMA stated: "CKD [chronic kidney disease]. Currently no evidence of DI [diabetes insipidus]. Apparently stable." However, the individual had a diagnosis of DI and was being managed by nephrology. Per the nephrology consult, dated 3/30/16, the assessment was Stage 4 (severe) CKD, diabetes insipidus, and Vitamin D deficiency. The consultant further stated that future dialysis would not be possible due to the individual's inability to cooperate. The PCP did not address these findings in any assessments (quarterly, IPNs) documented in the records, and this information was not referred to the IDT for review. The IHCP only noted that nursing would monitor the renal panel monthly and notify the MD of significant changes. The PCP did not address the three major issues related to CKD: 1) delaying or halting the progression of CKD; 2) diagnosing and treating the pathologic manifestations of CKD; and 3) timely planning for long-term renal replacement therapy.
- In September/October 2015, Individual #217 was hospitalized for bacterial pneumonia. She was rated at high risk for aspiration. The AMA included a brief plan related to GERD (i.e., status post (S/P) fundoplication, enteral nutrition, etc.). The AMA indicated the individual's tracheostomy was to be changed monthly (the IHCP stated daily, which likely was not correct). The IHCP should specify that an emergency tracheostomy kit is available, the location, etc. A medical plan for management of aspiration risk should include strategies to minimize risks including: 1) achieve optimal management of dysphagia via positioning, proper diet texture etc. (no episodes of choking, other signs and symptoms); 2) maintenance of good oral hygiene; 3) absence of untreated dental decay; 4) maintenance of adequate nutritional status (surrogate indicators include lab evidence, such as albumin/pre-albumin); 5) optimal management of drugs (those that increase ACB, sedating medications, and those that cause xerostomia (i.e., dry mouth); 6) maintenance of adequate hydration (based on physical assessment and labs); 7) increase in mobility; and 8) adequate control of chronic respiratory conditions (physical exam, pulse oximetry, and pulmonary function tests).
- With regard to hypothyroidism, Individual #217's AMA, dated 2/10/16, used old 2015 data stating: "under good control on synthroid." However, a lab value for thyroid stimulating hormone (TSH), dated 12/16/15, was decreased at .07. The Clinical Pharmacist commented on the suppressed TSH in the QDRR, dated 2/22/16. However, the PCP commented that the TSH was stable and in range. This was incorrect as the most recent lab value was low. There was no indication that the individual was clinically assessed (the only exam was that from the February 2016 AMA), or the thyroid studies were rechecked.
- Individual #326's AMA documented a diagnosis of osteoporosis. The plan was to continue medications and the goal was to have no trabecular fractures. The last documented DEXA was completed in 2012. The Center's response to the Monitoring Team's document request noted that there was no DEXA because the individual was exempt due to age (i.e., 76). There was no recent DEXA even though the individual continued to receive medical therapy with calcium, Vitamin D and denosumab. Therefore, the PCP had no objective means of measuring the efficacy of treatment.
- Individual #326's IDT rated her at medium risk for cardiac disease. While the AMA indicated that the individual was treated for hyperlipidemia, the management focused on maintaining a high high-density lipoprotein (HDL). This was in contrast to a

recent San Antonio SSLC DUE that indicated that online American Heart Association (AHA)/American College of Cardiology (ACC) calculators were used to guide therapy for hyperlipidemia based on the 10-year atherosclerotic cardiovascular disease (ASCVD) risk. For an individual age 76 years, the 10-year risk should be calculated. A decision should then be made regarding the intensity of statin therapy. The individual was on a beta-blocker for treatment of hypertension. The PCP did not provide any comments related to monitoring of heart rate prior to administering the medication. In May 2016, the QDRR noted that this 76-year-old had a heart rate of 50 beats per minute. In June 2016, the PCP subsequently discontinued the medication as the Clinical Pharmacist had recommended. Individual #326's last electrocardiogram (EKG) was done on 3/4/15.

- For Individual #222, for the time period of 1/25/16 to 4/26/16, nursing staff documented 16 episodes of coughing, several of which were associated with meals or medication administration; five episodes of emesis; and four episodes of difficulty swallowing. On 2/10/16, the PCP documented that the individual was seen for follow-up of the cough (the PCP did not document any prior assessments). The individual's lungs were noted to be clear and the plan was to continue current treatment. There was no discussion of aspiration as a possible etiology of the cough. On 3/23/16, the PCP noted that the individual was questioned and did not associate the cough with oral intake. The assessment was "f/u [follow-up] cough, wellness." The plan was to continue medications and treatment as ordered. On 4/11/16, the PCP noted again that the speech language pathologist (SLP) documented coughing during lunch on 4/11/16, and there were 12 reported/documented coughs. The conclusion was that: "No clinical evidence or documentation supporting 'continuous' or any other "swallowing' difficulty." There was no change in the medical plan. On 5/12/16, the PNMT requested a modified barium swallow study (MBSS). On 5/19/16, the Medical Director noted that the MBSS showed moderate to severe dysphagia with silent aspiration. Pharmacy and psychiatry were to review medication regimens. On 5/20/16, the Medical Director documented there was an IDT meeting to discuss the high risk of aspiration and implementation of dysphagia supports. While numerous professionals including nursing staff and the SPL were documenting evidence of aspiration and requesting a medical evaluation, the PCP did not utilize this data to move forward with an appropriate assessment. This resulted in a delay of four months in the implementation of appropriate supports.
- Moreover, the AMA for Individual #222 did not include an Assessment and Plan for each active medical problem. Significant problems such as hypertension and dysphagia were not discussed and did not have a plan. Thus, the AMA provided no information on the control of the individual's hypertension (presence or absence of end organ damage) or a plan to manage it. A review of the one-year of lab data did not document a urinalysis or other means of detecting of micro albuminuria. The IHCP provided targets for blood pressure and lipid values. However, there was no discussion of a 10-year ASCVD risk being calculated and how that would impact therapy. Related to cardiovascular risk, the IHCP noted that metabolic syndrome was "NA." However, the individual was at increased risk due to treatment with new generation antipsychotics (NGAs). He received medication for treatment of hypertension and hyperlipidemia, which are two metabolic syndrome criteria.
- Individual #220 was treated for a diagnosis of seizure disorder (two documented seizures). Previously, she was prescribed Dilantin, but now she was prescribed carbamazepine. Per the AMA, the last seizure was in 2002, but the seizure classification was not clear, and an electroencephalogram (EEG) was never completed. Her most recent neurology assessment was on 4/1/16 (previous 2013). Per neurology, the individual had a well-controlled seizure disorder with the last documented seizure in February 2002. The plan was to continue current medications. The AMA did not address any plan to assess the continued need for anti-epileptic drug (AED) use for an individual with an unclear seizure classification, a lack of documented EEG findings, and no seizures for approximately 14 years.
- Individual #306's AMA, signed on 1/25/16, stated that hypothyroidism was well controlled. However, lab work, dated

1/14/16, showed a TSH of 9.21 clearly indicating inadequate treatment. The previous study was done on 1/21/15. The QDRR, dated 2/23/16, made the recommendation to obtain a TSH based on the elevated January 2016 value. On 4/6/16, the repeat lab work showed continued inadequate treatment with a TSH of 6.03. The PCP did not address the abnormal TSH until the Clinical Pharmacist made the recommendation.

- Individual#151 had a history of seizure disorder, and in 2007, had a vagus nerve stimulator (VNS) implanted. The QDRR, dated 6/28/16, noted that an epileptology consult occurred on 5/18/16. Per the QDRR, the epileptologist documented continued breakthrough seizures and the VNS was adjusted. The AMA, dated 6/1/16, did not comment on the current status of the seizure disorder (i.e., how many seizures have been documented). The date of the last neurology evaluation was not documented nor was the last date for VNS interrogation and programming. Per the IRRF, the individual had six seizures for the review period, which was an increase from the previous year. The goal was to have no status or uncontrolled seizure disorder. The IRRF and IHCP did not acknowledge that the individual had a VNS, or that staff should receive training related to its use. There was nothing in the IHCP to indicate that the VNS would be used.
- Per Individual #115's AMA, dated 11/19/15, the individual had a seizure disorder that was "well controlled and stable on his meds." This was in stark contrast to the comments in the IRRF that indicated the individual had more than 40 seizures during the previous year. Moreover, the epileptology consult, dated 2/9/16, noted that the individual had intractable epilepsy with a VNS. The epileptologist requested videos of seizure activity for review. The IRRF noted that the individual had a VNS and uncontrolled seizures, but the AMA made no mention of this. Based on the information in the AMA, the PCP was not aware of the status of the individual's seizure disorder. There were no 2015/2016 quarterly medical summaries available.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.

Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs.

#	Indicator	Overall Score	Individuals: 95	262	217	326	222	220	306	151	115
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	28% 5/18	1/2	0/2	1/2	0/2	0/2	1/2	1/2	1/2	0/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, for the following individuals' chronic or at-risk conditions, PCPs implemented those action steps assigned to them: Individual #95 – GI problems, Individual #217 – aspiration, Individual #220 – constipation/bowel obstruction, Individual #306 – osteoporosis, and Individual #151 – seizures.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: The Center's performance on these indicators varied over the last two reviews and this review. Although it was good to see some improvement with some of the indicators, all of them will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	QDRRs are completed quarterly by the pharmacist.	78% 14/18	2/2	1/2	2/2	2/2	2/2	1/2	1/2	2/2	1/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	56% 10/18	0/2	2/2	1/2	0/2	2/2	2/2	1/2	0/2	2/2
	ii. Benzodiazepine use;	100% 8/8	2/2	N/A	N/A	N/A	N/A	2/2	N/A	2/2	2/2
	iii. Medication polypharmacy;	100% 14/14	2/2	2/2	2/2	2/2	N/A	N/A	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100%	2/2	2/2	N/A	N/A	2/2	2/2	N/A	N/A	N/A

		8/8									
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 10/10	2/2	2/2	N/A	N/A	2/2	2/2	2/2	N/A	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	75% 3/4	N/A	N/A	0/1	1/1	1/1	N/A	1/1	N/A	N/A
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: Overall, it did not appear that the QDRRs provided to the Monitoring Team were from the individuals' Active Records. For example, no date stamps from the Records Department were on the documents to note when they received them. In the future, the Center must provide documents from the Active Record.

b. For a number of individuals, labs were not up-to-date, or showed results that raised concerns. However, these individuals' QDRRs did not make corresponding findings and/or recommendations.

In the QDRRs for Individual #151, the three criteria he met for metabolic syndrome were noted, but without any indication that this placed him at increased risk.

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

d. When prescribers agreed to recommendations for the individuals reviewed, they generally implemented them. The exception was Individual #217 for whom a recommendation was made for a vision exam due in May 2016, but it was not done.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	57% 4/7	0/1	1/1	1/1		1/1	1/1		0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7	0/1	0/1	0/1		0/1	0/1		0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7	0/1	0/1	0/1		0/1	0/1		0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1		0/1	0/1		0/1	0/1

Comments: a. and b. Individual #326 and Individual #306 were edentulous. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

Although Individual #262, Individual #217, Individual #222, and Individual #220's goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For these seven individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services. Individual #306 was in the core group, so a complete review was completed for her. For Individual #326, who was at low risk for dental and who was in the outcome sample, the "deep review" items were not scored, but other items were scored.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall	95	262	217	326	222	220	306	151	115

		Score									
a.	Individuals have no diagnosed or untreated dental caries.	100% 6/6	1/1	1/1	1/1	N/A	1/1	1/1	N/A	N/A	1/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/A									

Comments: a. Individual #326, and Individual #306 were edentulous. For Individual #151, the Monitoring Team was unable to determine the last date of dental treatment. According to the IRRF, the IDT was making a referral for dental care, now that he was no longer on hospice.

It is important to note that although it was positive that individuals had restorations or extractions completed, for some individuals significant time had elapsed since the caries were originally diagnosed. For example:

- On 11/10/14, Individual #222 had an exam with x-rays that noted poor home care, and stated: "Multiple caries noted. The lesions have increased since the last exam." A TIVA consult was requested. A one line IPN entry, dated 11/10/15, stated: "rescheduled due to the DOJ exit." On 12/2/15, 12/14/15, 2/23/16, and 2/24/16, four refusals were documented. On 4/15/16, six restorations were finally completed, 17 months after the initial need was identified.
- On 11/24/14, Individual #262 was admitted to San Angelo SSLC. On 12/4/15, an exam was attempted, but the individual was uncooperative and a TIVA consultation was initiated. On 6/2/15, the individual was uncooperative with another attempt at an exam with pre-treatment sedation. Over 10 months after the initial exam was attempted, on 10/21/15, Individual #262 had an exam under TIVA and had eight extractions.

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

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: The Facility needs to focus on the provision and quality dental treatment.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral	0% 0/6	0/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A	0/1

	hygiene needs, unless clinically justified.										
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	71% 5/7	1/1	1/1	1/1	N/A	0/1	1/1	N/A	0/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	71% 5/7	1/1	1/1	1/1	N/A	1/1	0/1	N/A	0/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	0% 0/6	0/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A	0/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	25% 1/4	1/1	0/1	0/1	N/A	0/1	N/A	N/A	N/A	N/A
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									

Comments: Individual #326, and Individual #306 were edentulous.

Overall, it was concerning that the Dental Department, in concert with IDTs, had not implemented treatment and care for the individuals reviewed to assist them in maintaining optimal oral hygiene.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: Given that the Center attained 100% scores for Indicator a during this review and Indicators a through c during the Round 9 review (i.e., these indicators were N/A in Round 10), with sustained performance during the next review, indicators a through c will likely move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A				N/A					
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A				N/A					

Comments: a. through c. Individual #326 had a chipped denture, requiring no repair.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: The Center did not have consistent documentation regarding which individuals required suction tooth brushing, including measurable plans or strategies in individuals' ISPs, and/or documentation of implementation. Other areas that needed focused efforts included monitoring to ensure the quality of the technique, and inclusion of data reflective of the measurable goal/plan in ISP monthly reviews.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/1	N/A	N/A	N/A	N/R	N/A	N/A	N/A	0/1	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	50% 1/2			1/1					0/1	
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/2			0/1					0/1	
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/2			0/1					0/1	

Comments: For Individual #326, who was in the outcome group and was at low risk for dental, some indicators were not assessed.

a. and b. For Individual #217, the dental exam indicated it was not needed, but the IRRF noted suction tooth brushing was completed twice a day, and evidence was submitted to show it was implemented.

The annual dental exam stated that Individual #151 did not need suction tooth brushing, but the annual dental summary and IRRF stated it was provided twice a day. In response to the Monitoring Team's request #68, suction tooth brushing was required, but "there is no documentation of it being implemented." The Medication Administration Records appeared to indicate that chlorhexidene was being used for suction tooth brushing.

Outcome 9 – Individuals who need them have dentures.											
Summary: In comparison to the last two reviews, it was good to see some improvement with regard to the dentist's assessmefnt of the need for dentures for individuals with missing teeth.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	If the individual is missing teeth, an assessment to determine the	78%	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1

	appropriateness of dentures includes clinically justified recommendation(s).	7/9									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: Individual #220 had 22 missing teeth, but an assessment was not found regarding the appropriateness of dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained an area on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification, and document such notifications. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	50% 4/8	0/1	0/1	N/A	2/2	N/A	0/1	0/1	N/A	2/2
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.	13% 1/8	0/1	0/1		1/2		0/1	0/1		0/2
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/3	0/1	0/1		N/A		N/A	N/A		0/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/5	N/A	N/A		0/2		0/1	0/1		0/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/8	0/1	0/1		0/2		0/1	0/1		0/2

f.	The individual's acute care plan is implemented.	0% 0/8	0/1	0/1		0/2		0/1	0/1		0/2

Comments: The Monitoring Team reviewed eight acute illnesses and/or acute occurrences for six individuals, including Individual #95 – self-inflicted human bite on 2/16/16 requiring antibiotic therapy on 2/23/16; Individual #262 – cellulitis to right side of head on 3/26/16; Individual # 326 – seizure activity on 1/21/16, and acute on chronic congestive heart failure and fever of unknown origin on 3/15/16; Individual #220 – swelling and bruising to right hand; Individual #306 – idiopathic leukopenia, G-tube malfunction, and urinary tract infection (UTI); and Individual #115 – laceration on 1/31/16, and laceration on 6/17/16.

b. The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms was: Individual # 326 – seizure activity on 1/21/16. The nurses involved recognized this was the first seizure Individual #326 had since her craniotomy, and notified the physician.

e. For the following acute issues/occurrences, nursing staff had not developed acute care plans: Individual # 326 – seizure activity on 1/21/16, and acute on chronic congestive heart failure and fever of unknown origin on 3/15/16; and Individual #115 – laceration on 1/31/16. Common problems with the remaining acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing protocols; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur.

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

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

Individuals:

#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	50% 9/18	1/2	0/2	2/2	2/2	0/2	1/2	1/2	2/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e.,

Individual #95 – constipation/bowel obstruction, and weight; Individual #262 – weight, and seizures; Individual #217 – GI problems, and infections; Individual #326 – constipation/bowel obstruction, and seizures; Individual #222 – seizures, and other: pain; Individual #220 – constipation/bowel obstruction, and seizures; Individual #306 – GI problems, and weight; Individual #151 – constipation/bowel obstruction, and seizures; and Individual #115 – constipation/bowel obstruction, and seizures).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #95 – constipation/bowel obstruction; Individual #217 – GI problems, and infections; Individual #326 – constipation/bowel obstruction, and seizures; Individual #220 – constipation/bowel obstruction; Individual #306 – weight; and Individual #151 – constipation/bowel obstruction, and seizures.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

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

#	Indicator	Overall Score	Individuals: 95	262	217	326	222	220	306	151	115
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/8	0/1	N/A	0/1	0/1	N/A	N/A	0/2	0/1	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: As noted above, the Monitoring Team reviewed a total of 18 specific risk areas for nine individuals, and as available, the IHCPs to address them.

a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that

nursing interventions were implemented thoroughly.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
Summary: For the two previous reviews, as well as this review, the Center did well with the indicator related to administering medications according to the nine rights (c). However, given the importance of this indicator to individuals' health and safety and the fact that if nurses were following the nine rights, the MAR variances would not be as numerous as they are, the Monitoring Team will continue to review it until the Center's quality assurance/improvement mechanisms related to medication administration can be fully assessed and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual receives prescribed medications in accordance with applicable standards of care.	67% 10/15	0/1	1/2	2/2	0/1	2/2	2/2	0/1	2/2	1/2
b.	Medications that are not administered or the individual does not accept are explained.	43% 3/7	0/1	1/2	N/A	1/1	1/1	N/A	0/1	N/A	0/1
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).	83% 5/6	N/A	1/1	1/1	N/A	1/1	1/1	N/A	1/1	0/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	Not rated [N/R]									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds	N/R									

	before and after medication administration, which the IHCP or acute care plan should define.										
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1
f.	Individual's PNMP plan is followed during medication administration.	50% 3/6	N/A	0/1	1/1	N/A	1/1	0/1	N/A	1/1	0/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	67% 4/6	N/A	1/1	0/1	N/A	0/1	1/1	N/A	1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	17% 1/6	N/A	0/1	N/A	0/1	N/A	1/1	0/1	0/1	0/1
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of six individuals, including Individual #95 (not observed), Individual #262, Individual #217, Individual #326 (not observed), Individual #222, Individual #220, Individual #306 (deceased so no observation), Individual #151, and Individual #115.

a. and b. Problems noted included:

- The Medication Administration Records (MARs) for Individual #95, Individual #262, Individual #326, and Individual #115 showed omissions and/or MAR blanks for which variance forms were not provided.
- No MARs were provided for Individual #306.
- For Individual #95 and Individual #115, multiple blocks on the MARs were circled without explanation.

c. For Individual #115, prior to administration, medication was pre-signed on the electronic health record for the 5:30 p.m. block. The 1:00 p.m. block was missing on the electronic health record, when compared to the hard copy of the MAR. Although the nurse administered the medications within the standard of care (e.g., performing three quality checks), medication administration was

documented incorrectly due to problems with the electronic health record.

d. This indicator was not assessed during this review, but will be during upcoming reviews. State Office is working with the Centers to comply with these requirements.

e. At times, nursing staff did not document the reason, route, and/or the individual's reaction or the effectiveness of the PRN or STAT medication.

f. During onsite observations, it was concerning that nursing staff followed the PNMPs for only three out of six individuals.

g. For Individual #217, the nurse did not change gloves prior to the administration of eye ointment. For Individual #222, the nurse did not observe correct hand washing procedures, and did not use sanitized scissors to open a medication package.

h. For the records reviewed, evidence was not present to show that nursing staff provided instructions to the individuals and their staff regarding new orders or when orders changed.

i. When a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation was generally not present to show individuals were monitored for possible adverse drug reactions. The exception was for Effexor for Individual #220.

j. and k. For the individuals reviewed, Facility staff did not identify any possible ADRs.

l. and m. Facility staff were unable to produce the requested hard copies of the medication variances and the Avatar forms for the Monitoring Team. In addition, as noted above, observations and discussions revealed challenging and problematic computer systems issues that resulted in nursing staff needing to use hard copies of the MAR to ensure individuals received their prescribed medications. It will be important that these variances be quickly addressed, as well as tracked and analyzed so that corrections can be made to the system to prevent reoccurrence.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										

	i.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/14	0/2	0/1	0/1	0/2	0/2	0/2	0/2	0/2	N/A
	ii.	Individual has a measurable goal/objective, including timeframes for completion;	29% 4/14	0/2	0/1	0/1	0/2	2/2	1/2	1/2	0/2	
	iii.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/14	0/2	0/1	0/1	0/2	0/2	0/2	0/2	0/2	
	iv.	Individual has made progress on his/her goal/objective; and	0% 0/14	0/2	0/1	0/1	0/2	0/2	0/2	0/2	0/2	
	v.	When there is a lack of progress, the IDT takes necessary action.	0% 0/14	0/2	0/1	0/1	0/2	0/2	0/2	0/2	0/2	
b.		Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i.	If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	75% 3/4	N/A	1/1	1/1	N/A	0/1	N/A	N/A	N/A	1/1
	ii.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5		0/1	0/1		0/1				0/2
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	0% 0/5		0/1	0/1		0/1				0/2
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/5		0/1	0/1		0/1				0/2
	v.	Individual has made progress on his/her goal/objective; and	0% 0/5		0/1	0/1		0/1				0/2
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5		0/1	0/1		0/1				0/2

Comments: The Monitoring Team reviewed 14 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: GI problems, and weight for Individual #95; falls for Individual #262; skin integrity for Individual #217; aspiration, and falls for Individual #326; choking, and GI problems for Individual #222; choking, and falls for Individual #220; aspiration, and falls for Individual #306; and aspiration, and fractures for Individual #151.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: choking, and GI problems for Individual #222; falls for Individual #220; and aspiration for Individual #306.

b.i. The Monitoring Team reviewed five areas of need for four individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: weight for Individual #262; aspiration for Individual #217; aspiration for Individual #222; and falls, and fractures for Individual #115.

The PNMT reviewed Individual #222 related to a choking event and aspiration risk, but he was not added to the PNMT caseload. It appeared that the PNMT should have provided an assessment in that on 5/19/16, he aspirated during an MBSS. The PNMT meeting/review occurred on that date. The MBSS recommended treatment and repeat swallow study after treatment.

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

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/11	0/1	0/2	0/1	0/2	0/1	0/1	N/A	0/1	0/2
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	33% 1/3	0/1	0/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A

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

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

- Individual #95's IDT reported that over three months, she refused to be weighed, but then in May when she was weighed, she had lost 16 pounds (i.e., 155.2 pounds in January 2016, and no weight recorded until May, when she weighed 138.6). The IDT should have addressed the issue of refusals to be weighed much sooner.

- Individual #262 had 17 falls over three months from March through June 2016, yet the IDT did not make a referral to the PNMT, and the only ISPA related to falls occurred on 6/1/16. In addition, Individual #262's IDT should have addressed her significant weight loss across 2015.
- Although Individual #217's IDT referred her to the PNMT, they did not incorporate the findings from the PNMT assessment into her IHCP.
- For Individual #326, the OT/PT assessment, dated 3/22/16, recommended an MBSS. In addition, an IHCP in the ISP, dated 4/7/16, indicated that the speech language pathologist (SLP) had an order for an MBSS. However, it was not until 5/12/16 that an MBSS was completed, and on 5/19/16, the PNMT discussed the findings. At an ISPA meeting on 5/20/16, the IDT did not review the findings of the MBSS, but rather stated Individual #326 had one and that they needed to regulate her fluid intake and she needed a Wonderflo cup. The IDT agreed to the change, but presented no further plan, such as updating the PNMP, providing staff training, monitoring, follow-up, etc.
- Individual #326 fell three times in November, but the IDT did not meet until 12/14/15, after a fourth fall occurred on 12/13/15. On 12/18/15, the PCP noted that the individual was being assessed for dragging her left foot and quadriceps weakness. PT was to follow. On 12/21/15, the PCP conducted an assessment and documented that the individual was not communicative and was unable to walk. She was referred to the ED for a decreased level of consciousness and leaning to the left. The individual underwent a craniotomy with evacuation of a subdural hematoma.
- Individual #115 had six falls during the month of May 2016, but the IDT did not hold an ISPA meeting until 5/24/16, which was two days after the sixth fall.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.

Summary: Although some improvements were seen from the last two reviews, during numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should continue to identify the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	64% 45/70
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.	13% 1/8

Comments: a. The Monitoring Team conducted 70 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 16 out of 22 observations (73%). Staff followed individuals' dining plans during 25 out of 42 mealtime observations (60%). Transfers were completed correctly four out of six times (67%).

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: The Center had not made progress on this indicator.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1	N/A
Comments: a. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: It was good to see that some OT/PT goals/objectives developed for individuals reviewed were clinically relevant, and measurable. However, for individuals reviewed, IDTs overall did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	50% 5/10	N/A	3/3	0/1	0/2	N/A	0/1	N/A	0/1	2/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	50% 5/10		3/3	0/1	0/2		0/1		0/1	2/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/10		0/3	0/1	0/2		0/1		0/1	0/2
d.	Individual has made progress on his/her OT/PT goal.	0% 0/10		0/3	0/1	0/2		0/1		0/1	0/2
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10		0/3	0/1	0/2		0/1		0/1	0/2
Comments: a. and b. Individual #95 had functional motor skills, and required some assistance with self-help skills, depending on her level of agitation, so a goal/objective was not indicated. Similarly, Individual #222 had functional motor and self-help skills, so a goal/objective was not indicated. Individual #306 had a need for PNM supports, but there was no indication that skill acquisition											

programs or other goals were necessary or appropriate to meet her needs.

The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #262 (i.e., sit-stand, walking, and bridging), and Individual #115 (i.e., sit-to-stand transfer, and ambulation). For Individual #115, his annual assessment, dated 11/12/15, identified that he had some motor deficits related to ambulation and falls from a standing position, but indicated that his unpredictable behavior and difficulty redirecting him, and poor ability to follow instructions would make it challenging for him to learn a new skill. On 6/22/16, he was referred to PT for an acute PT assessment, which was completed on 6/23/16, due to bilateral sacroplasty after having sustained sacral fractures likely the result of the traumatic fall on a wooden column in the living room of his home. Although Individual #326 had two goals that were measurable, they were not incorporated into her ISP through ISPA meetings. Only goals/objectives incorporated into the ISP or and ISPA are considered for the scoring of this outcome.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Unfortunately, in some cases, it appeared therapists maintained data, but this information was not incorporated into integrated ISP progress reports (e.g., for Individual #262's goals/objectives).

Individual #95 and Individual #306 were part of the core group, and so the Monitoring Team conducted full monitoring of their supports and services. Individual #222 did not require a goal/objective for OT/PT supports, but he did have OT/PT needs, so a full review was conducted for him. For the remaining five individuals, full reviews were conducted due to a lack of clinically relevant, achievable, and measurable goals/objectives in ISPs/ISPAs to address areas of OT/PT need, and/or because integrated ISP progress reports did not provide an analysis of related data.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	71% 5/7	N/A	3/3	N/A	2/2	N/A	N/A	N/A	0/1	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	40% 2/5	N/A	0/3	N/A	2/2	N/A	N/A	N/A	N/A	N/A

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

- For Individual #262, on 4/12/16, the PT completed a discharge summary that stated that two of three goals were only partially met, but the individual would be discharged. Insufficient rationale was provided regarding why therapy would not continue to ensure that these goals were met. An ISPA did not reflect outcomes of intervention, plan for home program, etc.

- No evidence was submitted of implementation of Individual #151's range of motion home program.
- Although one IPN was submitted in reference to Individual #115's direct PT program, it was not included in the continuous record of IPNs.

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

Summary: Given that over the last two review periods and during this review, individuals observed generally had clean adaptive equipment (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%) that was in working order (Round 9 – 86%, Round 10 – 96%, and Round 11 - 100%), Indicators a and b will move to the category of requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – 45%, Round 10 – 85%, and Round 11 - 63%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

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

#	Indicator	Overall Score	Individuals: 13	338	8	235	213	347	328	79	258
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 16/16	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 16/16	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	63% 10/16	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1

#	Indicator		Individuals: 248	228	92	335	31	217	151		
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1		
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1		
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	0/1		

Comments: a. The Monitoring Team conducted observations of 16 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see.

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

c. Based on observation of Individual #13, Individual #338, Individual #167, Individual #258, and Individual #151 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors. In its comments on the draft report, the State disputed this finding for Individual #13, and Individual #338. Unfortunately, these individuals' PNMPs did not confirm the information the State provided in its comments. PNMPs, for example, should state whether or not individuals can reposition themselves, and, if so, if they need staff to remind them to correct their positions to reduce risks. Individual #235's wheelchair had no footrests.

Domain #4: Individuals in the Target Population will engage in meaningful activities, through participation in active treatment, community activities, work and/or educational opportunities, and social relationships consistent with their individual support plan.

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. Two of these, regarding the facility's collaboration with the local public school district and communication, had sustained high performance scores and will be moved the category of requiring less oversight. This included one entire outcome: outcome #9 for skill acquisition/engagement.

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

Given that most ISPs did not yet contain personal goals and action plans that met the various criteria, the indicators related to progress were also not met. For the goals that met criterion with indicator 1, there were not consistent reliable data available to assess progress.

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

For a number of the individuals reviewed, IDTs had developed clinically relevant and measurable outcomes with regard to individuals' communication skills, which was good to see. However, in a number of instances, integrated monthly reviews were not available, were late, and/or did not include an analysis of the data, or the SLPs had not conducted monitoring to ensure data reliability. As a result, outcomes related to communication could not be measured for these individuals.

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

Skill acquisition plans existed for each individual, but they were inadequate in terms of content, implementation quality, and review. The facility was initiating a pilot project to improve SAPs.

It was good to see that San Antonio SSLC measured engagement and had goals for engagement. Goals, however, were not achieved and observations by the Monitoring Team found one-third of the individuals to be engaged in activities.

San Antonio SSLC had one individual who attended school. The facility had a good working relationship with the San Antonio school district.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that goals were not yet individualized and did not meet criterion with ISP indicators 1-3, the indicators of this outcome also did not meet criteria. The handful of goals that were developed were not implemented and/or data were not available to assess progress. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	95	262	84	326	217			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: Once San Antonio 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.

4-7. Overall, personal goals did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

For the goals that met criterion with indicator 1, none met criteria for indicator 3, that is, there were not consistent reliable data available to assess progress.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	95	262	84	326	217			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	67% 4/6	1/1	0/1	1/1	0/1	1/1	1/1			
40	Action steps in the ISP were consistently implemented.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

Comments:
39. Staff were basically knowledgeable regarding individual's risks and support needs. In addition, staff were familiar with individuals' goals and action plans. For Individual #95 and Individual #84, it was not possible to confirm that staff were competent to implement their ISPs due to the overall lack of data supporting implementation.

40. Individual #217 was the only individual with consistently documented implementation of all action plans.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Determining whether SAPs are progressing and taking actions to develop new SAPs or to modify existing SAPs was part of the upcoming pilot project to improve skill acquisition programming and engagement at San Antonio SSLC. This outcome and its indicators will continue to receive active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
6	The individual is progressing on his/her SAPS	9% 2/22	0/3	1/3	0/3	1/3	0/3	0/2	0/2	0/2	0/1
7	If the goal/objective was met, a new or updated goal/objective was introduced.	50% 1/2	N/A	N/A	1/1	N/A	0/1	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/7	N/A	N/A	0/2	0/2	0/1	N/A	0/1	0/1	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	36% 8/22	2/3	3/3	1/3	1/3	0/3	0/2	0/2	1/2	0/1

Comments:
6. Individual #262's operation of her audio device and Individual #290's imitation of signs were the only SAPs that had reliable data indicating progress. There was insufficient data to determine progress for Individual #109's seal bags, Individual #84's write his address, Individual #214's shave and set the time on the washer, Individual #41's shed paper, and Individual #187's make a purchase SAPs. Several individuals appeared to be progressing in their SAPs, however, the data were not demonstrated to be reliable (e.g., Individual #41's shaving SAP), and/or not practical/functional (e.g., Individual #199 swabbing his mouth SAP), so these SAPs were scored as not progressing.

7-9. Individual #95's put on her shirt, and Individual #41's shaving SAP objectives were achieved. Individual #95's June 2016 review SAP sheet indicated that this SAP was achieved, and stated that a new SAP would be developed. Individual #41's SAP, on the other hand, was achieved in May 2016, but continued through June 2016.

Similarly, in none of the seven SAPs that were judged as not progressing (e.g., Individual #84's complete vocational task SAP), was there

evidence that actions were taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP). Overall, there appeared to be data based decisions to continue, discontinue, or modify SAPs in only eight of the SAPs.

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: Performance was about the same as during the last review. More focus is required to meet this indicator. The facility's pilot program is designed to do so. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
13	The individual's SAPs are complete.	23% 5/22	1/3	1/3	0/3	2/3	1/3	0/2	0/2	0/2	0/1
Comments: 13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although only five SAPs were found to be complete, the majority of the other SAP components were found in most SAPs. A common missing component was the use of a task analysis. Many of the SAPs contained just one step suggesting that these either should be broken down into more steps to be most effective (e.g., Individual #199's play loteria SAP), or represented compliance issues rather than the acquisition of new skills (e.g., Individual #109's count change SAP). Another common missing component was the absence of clear SAP training instructions. All SAPs indicated that they utilized forward chaining, or total task training procedures. None of the SAPs, however, described how to implement these training methodologies. Further, none of the DSPs implementing the SAPs or interviewed by the Monitoring Team understood the differences associated with these different training procedures. Improving the quality of the SAPs should be a priority for the facility.											

Outcome 5- SAPs are implemented with integrity.											
Summary: These are very important indicators and are part of the facility's upcoming pilot program to improve the development, design, and implementation of SAPs. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
14	SAPs are implemented as written.	50% 2/4	0/1	0/1	N/A	1/1	N/A	N/A	N/A	1/1	N/A
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/22	0/3	0/3	0/3	0/3	0/3	0/2	0/2	0/2	0/1
Comments:											

14. The Monitoring Team observed the implementation of four SAPs. Two were judged to be implemented with integrity (Individual #262's operate her audio device SAP, and Individual #199's play loteria SAP). The other two SAPs observed by the Monitoring Team were not implemented with integrity. The DSPs implementing Individual #109's wash clothes SAP and Individual #290's imitate signs SAPs did not follow the task analysis steps, and neither DSP could identify the training step.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. San Antonio SSLC recently began to conduct SAP integrity checks. As of 6/30/16 they established that each SAP will have an integrity measure at least twice every year. Additionally, they established 80% as the minimum level of an acceptable integrity score. None of the SAPs, however, achieved this schedule of SAP integrity.

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

Summary: Both indicators showed some improvement from the time of the previous review. Both are also part of the facility's upcoming efforts to improve the entire SAP program at San Antonio SSLC. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	290	95	262	41	214	84	199	187
16	There is evidence that SAPs are reviewed monthly.	27% 6/22	0/3	0/3	0/3	1/3	3/3	0/2	0/2	2/2	0/1
17	SAP outcomes are graphed.	82% 18/22	3/3	2/3	3/3	1/3	2/3	2/2	2/2	2/2	1/1

Comments:
16. Only six SAPs were reviewed in QIDP monthly reports and included a data based review. The majority of SAPs were reviewed in QIDP monthly reports, however, many reviews did not include a review of SAP data (e.g., Individual #262's SAPs). Additionally, the most recent QIDP monthly review for some individuals was more than three months old (e.g., Individual #95), indicating that monthly reviews were not regularly occurring.

17. There was evidence that all SAPs were graphed, however, some were not graphed in a way that allowed one to visually assess trends. For example, Individual #290's use the hamper SAP specified a total task training methodology and graphed the highest step achieved. It would be more useful to visually examine improvement, however, if the number of steps achieved were graphed.

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

Summary: It was good to see that San Antonio SSLC measured engagement and had goals for engagement. Goals, however, were not achieved and observations by the Monitoring Team found one-third of the individuals to be engaged in activities. This outcome and its indicators will remain in active monitoring.

#	Indicator	Overall	Individuals: 109	290	95	262	41	214	84	199	187

		Score									
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	33% 3/9	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
Comments: 18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found three (Individual #84, Individual #109, Individual #290) of the nine individuals (33%) were consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations). 19-21. San Antonio SSLC tracked engagement in all residents and treatment sites multiple times per month, regularly collected IOA, graphed the results, and provided monthly data to the managers of those sites. Their established engagement goal was individualized to each residence and day program site. The facility's engagement data indicated that 33% of the residential and day treatment sites of the individuals achieved their goal level of engagement.											

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Indicators 22 and 23 showed some improvement from the previous review, that is, IDTs were setting some goals for community activities and SAP training. Moreover, some of these goals were achieved. Plans for addressing barriers to these community activities and trainings were not yet part of the facility's operations. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	290	95	262	41	214	84	199	187
22	For the individual, goal frequencies of community recreational activities are established and achieved.	67% 6/9	1/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	25% 1/4	0/1	1/1	N/A	N/A	0/1	N/A	N/A	0/1	N/A
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 22-24. San Antonio SSLC established individualized goals for the frequency of community outings and SAP training in the community.											

Individual #109, Individual #290, Individual #41, Individual #84, Individual #199, and Individual #187 achieved their individualized community outing goals. Individual #262 did not have a community outing goal. Only Individual #290 achieved her SAP training community goal. There was not a goal for SAP training in the community for Individual #95, Individual #262, Individual #214, Individual #84, and Individual #199. None of the individuals had plans to improve/establish community recreational or SAP training goals.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: San Antonio SSLC had one individual who attended school. The facility had a good working relationship with the San Antonio school district. The requirements for this indicator have been met for many years and this indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	118								
25	The student receives educational services that are integrated with the ISP.	100% 1/1									
Comments: 25. None of the individuals at San Antonio SSLC were currently attending public school. In order to score this indicator Individual #118, who graduated from public school in May 2016, was reviewed. Individual #118 received educational services that were integrated into his ISP.											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2	0/1				0/1				
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2	0/1				0/1				
d.	Individual has made progress on his/her goal(s)/objective(s) related	0%	0/1				0/1				

	to dental refusals; and	0/2									
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2	0/1				0/1				
Comments: For Individual #95, the IRRF clearly documented six refusals in nine months, noting that the individual was overdue for her dental annual exam by nearly two years. However, her IHCPs included no goals related to strategies to achieve better cooperation. She continued to require TIVA for basic dental care such as exam, x-rays, and cleanings. Individual #222's ISP documented "a plan needs to be discussed to ensure he attends his appointments," but no plan was submitted.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: It was positive that during the previous review and this one, the Center had scored well on Indicators a and b. However, in order to measure outcomes for individuals, reliable data needs to be collected, and analyzed. All of these indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	89% 8/9	1/1	1/1	1/1	0/1	N/A	2/2	1/1	1/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	89% 8/9	1/1	1/1	1/1	0/1	N/A	2/2	1/1	1/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/7	0/1	0/1	0/1	0/1	N/A	0/1	N/A	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1	0/1	N/A	0/1	N/A	0/1	0/1
Comments: a. and b. Individual #222 communicated verbally and had no identified communication needs. The goals/objectives that were clinically relevant, as well as measurable were Individual #Individual #95's goal/objective related to communicating: "I want," Individual #262's goal/objective related to activating her voice output device, Individual #217's goal/objective related to making a choice, Individual #220's goals/objectives to identify a picture of a functional object, and name and object when presented with a picture of a functional object – both were included in the ISP of 3/1/16, Individual #306's goal/objective related to a change in facial expression, Individual #151's goal/objective related to responding to his name, and Individual #115's goal/objective related to making a choice by reaching for an item.											

As noted above, Individual #217 had a clinically relevant, and measurable goal related to making a choice through eye contact. Although from the data presented, it appeared she was making progress, the reliability of the data could not be confirmed due to the fact that the SLP had not completed monitoring to ensure the program was being completed with integrity.

In its comments on the draft report, the Facility requested more information about Individual #362. The SLP provided no rationale for not working on cognitive/communication skills related to the individual's diagnosis of Alzheimer's disease.

c. through e. Because Individual #222 was part of the outcome group no further review was conducted. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives (i.e., it is not sufficient to say "individual progressed"), and/or a lack of IDT analysis and/or action when progress did not occur.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	262	217	326	222	220	306	151	115
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/8	0/1	0/1	0/1	N/A	N/A	0/2	0/1	0/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Evidence was not present to show that the strategies were implemented. Sometimes, data sheets showed implementation (e.g., Individual #151), but integrated reviews did not carry this information forward. In other instances, data sheets showed inconsistent implementation.											

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.	
Summary: Given that over the last two review periods and during this review, individuals observed generally had their AAC devices with them and readily available (Round 9 – 100%, Round 10 – 82%, and Round 11 - 92%), Indicator a will move to the category of requiring less oversight. Improvement was seen with regard to individuals using their AAC devices functionally, and the Center should continue its efforts in this regard. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for	Individuals:

these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]											
#	Indicator	Overall Score	88	50	180	79	258	92	31	335	151
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	92% 11/12	1/1	1/1	1/1	2/2	1/1	1/1	1/1	1/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	82% 9/11	0/1	N/A	1/1	2/2	1/1	1/1	1/1	1/1	0/1
			Individuals:								
#	Indicator		119	284							
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	1/1							
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		1/1	1/1							
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	100% 2/2									
Comments: b. For Individual #88, staff prompted him to press the button if he wanted a drink, instead of asking him if wanted a drink, and waiting for him to answer using the button.											

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, the Admissions and Placement Coordinator and Post Move Monitor had both recently accepted new positions at the facility. The facility was in the early stages of identifying their replacements.

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

Five individuals transitioned from the facility to the community since the last monitoring review. Two were reviewed for this domain. One individual had a complicated history of behavioral, psychiatric, and medical problems. Both had numerous supports defined in the CLDP and it was positive that the facility had made a diligent effort to address their needs. Most supports, but not all, were measurable. To ensure that the list of supports is comprehensive, the APC, transition specialists, placement coordinators, and post move monitor need to work with IDT members and thoroughly review documents (e.g., ISPs, transition assessments) to ensure that all preferences, needs, and recommendations are included in the pre and post move supports.

The facility continued to provide good post move monitoring, though some improvements in actions and in documentation are required in order to meet criteria with all indicators.

No negative events had occurred for either individual.

IDTs were highly involved in the transitions, as well as were the individuals themselves. Transition assessments, however, needed much improvement.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.	
Summary: The CLDPs contained many pre and post move supports. Many were measurable and many were individualized as required by this outcome. To ensure that the list of supports is comprehensive, the APC and her staff need to work with IDT members and thoroughly review documents (e.g., ISPs, transition assessments)	Individuals:

to ensure that all preferences, needs, and recommendations are included in the pre and post move supports. These two indicators will remain in active monitoring.											
#	Indicator	Overall Score	173	201							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments:
Five individuals transitioned from the facility to the community since the last monitoring review. Two were included in this review (Individual #173 June 2016, Individual #201 March 2016). Both transitioned to group homes that were part of the State's Home and Community-based Services program (HCS) and both were reported to be doing well overall. The Monitoring Team reviewed these two transitions and discussed them in detail with the incumbent San Antonio SSLC Admissions and Placement Coordinator (APC), and the Post Move Monitor (PMM) while onsite. The newly hired APC was also able to participate in a portion of the discussion.

1. Both Individual #173 and Individual #201 had numerous supports defined in the CLDP, but not all were measurable.
    - Individual #173's five pre-move supports were generally measurable, although in one case the outcome was not clearly defined. The support, for obtaining needed furnishings for his room, called for related paperwork to be completed by 5/29/16 and noted this would be dependent on DADS approval. Since he was scheduled to transition on 6/1/16, it was unclear what action would be required or even possible if not approved.
    - Individual #173 had 32 post move supports and five of these were not clearly measurable. Three of the five were subject to interpretation, indicating the provider was to 1) make every effort to schedule appointments so as not to interfere with work schedule, 2) provide options for a healthy diet, and 3) provide healthy snack options. These all required the PMM to evaluate the level of effort and determine what would constitute healthy meals and snacks. The remaining two were even vaguer and did not provide criteria for either the PMM or the provider staff. These called for 1) the RN to document weight monthly and "provide any follow-up if weight fluctuates dramatically," and 2) staff to provide informal prompts to ensure he completes personal grooming. The former required the reader to determine not only what constituted a dramatic fluctuation, but also what any follow-up was needed. The latter did not address toothbrushing, showering, and using deodorant, all specified as needs in the CDLP and assessments.
    - For Individual #201, 11 of 14 pre-move supports were measurable. Those that did not meet criterion were related to inservice training, none of which clearly specified the method of training or how competency would be determined. One support indicated the San Antonio SSLC behavior analyst would determine competency, but did not specify how this would occur.
    - Individual #201 had 71 post move supports and most were measurable, providing various methods for the PMM to evaluate whether supports were in place. Those that did not meet criterion included the following: 1) follow-up training to be provided did not include any competency provisions; 2) nursing staff was to make every effort to schedule appointments in the afternoon, but there was no staff interview to ensure awareness; 3) provider staff were to ensure Individual #201 had access to water, but there were no criteria as to quantity or frequency and no staff interview to ensure knowledge; 4) provider was to offer physical activities she enjoys such as garage sales per her preference, but no frequency for such activities was specified;

and 5) two supports required all staff to have understanding of and follow the Psychiatric Support Plan, but there were no criteria for expected staff knowledge.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs.

- Past history, and recent and current behavioral and psychiatric problems: Neither the ISP or assessments provided sufficient history regarding behavioral and psychiatric needs for Individual #173 and Individual #201. Examples included:
  - Individual #173's behavioral history was not well documented or represented in the supports. His assessments described a history of aggression, which had improved to very low levels, but the only support defined was for the BCBA to be available for consult. There were no supports related to training or staff knowledge, even regarding known current triggers, such as watching Scarface or other violent movies or people" getting into his stuff." This was of particular concern because two other supports called for him to have opportunities to watch DVDs at home as well as go to movies in his community with peers/friends. Further documentation requested by the Monitoring Team demonstrated that provider staff had participated in training related to these behaviors at the time of his pre-move visits, which was positive, but also re-affirmed the need for a staff knowledge support in this area.
  - For Individual #201, the CLDP provided no specific history of behaviors, triggers for aggression, or the nature of self-injurious behaviors, even though a quarterly psychiatric note and a Transition Specialist note, both completed in December 2015, documented that the behaviors were not only historical, but also recent. There was a good support developed related to strategies for reducing her anxiety over upcoming activities, but several other supports requiring all staff to have an understanding of and follow the Psychiatric Support Plan had no criteria for what the expected staff knowledge would be.
  - Individual #173 and Individual #201 were both taking psychiatric medications, but there were no supports for staff knowledge of side effects to be monitored.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: There were a number of concerns identified by the Monitoring Team in these areas:
  - For Individual #173, supervision requirements were addressed, but some healthcare and risk needs were not. Examples included:
    - A toothbrushing support was not specifically addressed, even though it was indicated as needed in several assessments. The dental assessment indicated he had fair oral hygiene, rather than the good rating incorrectly reported in Nursing Discharge Plan, and recommended a formal toothbrushing plan twice a day to regain good hygiene. The previous ISP also noted a continued need for staff assistance with dental care.
    - Other health risks identified in the IRRF and assessments were not clearly addressed. There was no support for exercise despite being referenced in various assessments. There was also no identification of his medium risk for medication side effects or a support for monitoring and/or staff knowledge in this area.
    - The medical and psychiatric assessments identified the importance of not challenging Zyprexa, but there was no support developed related to ensuring knowledge of the community health care providers.
    - Individual #173's sexual assessment indicated he liked to have girlfriends and one of his preferences was to

look at magazine with pretty girls, but there was no description of any interaction he may have had with women. There was also no recommendation regarding needed education regarding healthy relationships for this young man who will be relatively independent in his movement about the community.

- For Individual #201, the IDT identified over 80 pre and post move supports, many of which were related to safety, medical, healthcare, therapeutic, risk, and supervision needs. This was good to see and, moreover, the IDT had worked to ensure that her kidney disease and dialysis needs would be met. There were, however, still some needs indicated in various assessments and/or the CLDP narrative that were not translated to supports. Examples included:
  - Only nursing staff should clip Individual #201's nails due to her diabetes diagnosis.
  - A follow-up physician visit was to have been scheduled after a recommended B-12 level was drawn.
  - The IHCP indicated oxygen saturation levels and vital signs were to be checked daily, but there was no discussion as to why this may have been necessary, nor was a support developed.
  - There was a service objective for walking in the IHCP related to Individual #201's weight risk, but there was no exercise support identified or discussed in the CLDP.
  - The IHCP indicated procedures to the left arm should be avoided related to the fistula for impending hemodialysis. This was not addressed related to staff knowledge.
  - The supervision level was not well-defined in the CLDP, stating variously it was "routine" on all three shifts, "24 hour immediate access to staff when in the community" and "always supervised." The support called for "direct access to trained staff at all times." San Antonio SSLC transition staff agreed during discussion that this support could have been more clearly defined, such as calling for 24 hour awake staff who would allow Individual #201 privacy, but be within earshot at all times, and then further specifying activities requiring more direct supervision and assistance, such as personal care.
  - It was noted Individual #201 did not take her glucometer or check her blood sugar when visiting her mom and the narrative further indicated whether this could continue would be at the discretion of her community physician. There was no specific support to follow-up and obtain the PCP's decision/feedback.
  - In August of 2015, Individual #201 required ER treatment with Narcan and potassium. The provider questioned the etiology and whether this might happen again, but there was no clear explanation provided as to why Narcan was needed.

- What was important to the individual was captured in the list of pre-/post-move supports:
  - There were many supports for Individual #173 related to his employment preferences, in particular, as well as participation in Special Olympics and maintaining relationships with two long-standing friends. This was positive. There were significant preferences that were not addressed, though, including the following:
    - Preferences included wanting to contact his family. The social assessment provided only very vague information about Individual #173's relationship with his family, only an allusion to his parents having lost custody, with no interaction documented since his admission in 2011. It was noted he asks about them in the fall and it is "best to change the subject." This did not adequately address the potential risks and or benefits of his desire to have a relationship with his biological family or provide any strategy for helping him cope with this relationship issue. The Monitoring Team notes that this was considered to be at the root of several behavioral incidents that had been reported at the time of the 45-Day PMM visit and remained unresolved at

this time.

    - Individual #173 was reported to want to attend church in community, which would have been an excellent way to promote community integration and development of relationships, but there was no discussion or support.
    - Individual #173 indicated one of his primary criteria for choosing a home in the community was going on many outings, but the only support was at least one opportunity per month to attend a movie of his choice with peers/friends. Center staff noted during discussion with the Monitoring Team that this home was known to engage in frequent outings, but it would still have been prudent to define a specific expectation that was in line with his desires.
    - There was no support that addressed opportunities to visit with friends and staff at Corpus Christi SSLC, despite his stating he had three friends there he wanted to continue to visit.
    - His stated interest in participating in Boy Scouts and learning to cook were not addressed.
  - What was important to Individual #201 was well-addressed overall in the supports defined. The Monitoring Team was concerned that the CLDP narrative stated in the vocational section that Individual #201's vision was to obtain community employment working in fast food or janitorial, but there was no further discussion and no support.

- Need/desire for employment, and/or other meaningful day activities: Employment supports for Individual #173 were numerous and explicit in terms of things that should happen with DARS, benefits counseling and other work-related activities. While this was scored as meeting criterion overall, the Monitoring Team noted his personal goal to obtain a second job was not expressly addressed as an outcome, but should have been. For Individual #201, this aspect was not as well addressed. In the vocational section, the CLDP narrative stated her vision was to obtain community employment working in fast food or janitorial, but there was no discussion and no support developed, as described above. The day habilitation setting had no paid work component, which she had been engaged in at the center. Center staff noted during discussion with the Monitoring Team that Individual #201 had chosen this setting, but the CLDP should have addressed employment and at least have provided a justification.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success: Both of the CLDPs addressed positive reinforcement, incentives, and other motivating components well. For Individual #173, these focused on supports for valued items and activities as well as substantial assistance with obtaining a second job. For Individual #201, there were detailed supports describing preferred and effective reinforcers, as well as how and when to provide them.

- Teaching, maintenance, participation, and acquisition of specific skills: Individual #173's supports included doing laundry and learning to transfer on the bus route, but did not include learning to shave, toothbrushing, or other independence in managing personal hygiene. All of these were important not only for his health but also for maintaining his employment. Individual #201's supports in this area were more thoroughly addressed based on her needs, in that they included informal programs for toothbrushing and using a hamper, a formal program for learning to pack a renal friendly diet lunch, and day habilitation training objectives to be implemented within 45 days. Overall, this was scored as compliant for Individual #201, although the Monitoring Team noted in assessments other supports that could also have been considered, including verbal prompts for thorough bathing and to throw away trash.

- All recommendations from assessments are included, or if not, there is a rationale provided: For both individuals, there were a number of recommendations that were either not addressed or did not have an adequate rationale provided for not being included. These included:
  - For Individual #173, the CLDP did not address the following recommendations from various assessments or provide a rationale for their non-inclusion: toothbrushing (formal program or prompts) using a telephone, carrying his contact information in a wallet, exercise, and the recommendation to not challenge Zyprexa.
  - For Individual #201, the CLDP did not address a needed ENT consult, follow-up needed after the B-12 level was drawn and side effects monitoring. The IDT also modified recommendations from assessments without providing a justification as follows:
    - The medical/psychiatry section indicated a psychiatric visit in the community should occur within 6 weeks of transition, but the IDT changed this to 60 days without providing justification.
    - The dental assessment recommended visits every three to four months, but IDT determined six month intervals "would be fine," with no other justification and no dental staff involved in that decision.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: The facility continued to provide good post move monitoring, though some improvements in actions and in documentation are required in order to meet criteria with these indicators. San Antonio SSLC scored well on indicators 3, 9, and 10, and has so in the past, but with the imminent change in the APC and PMM positions, these three indicators, as well as all the indicators in this outcome, will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	173	201								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1								
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	50% 1/2	0/1	1/1								
6	The PMM's scoring is correct based on the evidence.	50% 1/2	0/1	1/1								
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely	0% 0/2	0/1	0/1								

	manner.											
8	Every problem was followed through to resolution.	50% 1/2	0/1	1/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	100% 1/1	N/A	N/A								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	N/A	N/A								

Comments:

3. Post-move monitoring had been completed for two visits for Individual #173 thus far. Individual #201 had all three visits completed. Each of these post-move monitoring visits were within the required timeframes, included all locations where the individual lived or worked, were done in the proper format and included comments regarding the provision of every support. The comments were very helpful for the reader to understand how supports were provided and how they were assessed by the PMM.

4. Reliable and valid data that report/summarize the status regarding the individual's receipt of supports were not available for all supports.

- For Individual #173, pre-move supports appeared to have valid and reliable data and many post-move supports had reliable and valid data based on a review of both the support data and the additional information contained in the areas of concern. Post-move supports that did not provide sufficient data included:
  - Individual #173 had a support to have ready access to staff to help him become familiar with new home and neighborhood, but the PMM only addressed staff availability with no questions or information about how they might be helping him gain needed familiarity.
  - Another support called for the RN to make every effort to schedule appointments that would not conflict with Individual #173's work schedule. This was marked as NA because no appointments had been scheduled, but the PMM should have interviewed the RN and documented awareness of this support.
  - A support called for provider staff to use the DADS Nurse and Behavioral Health Line if needed. For the 7-day visit, data only indicated there had been no issues necessitating support, but the PMM should have interviewed staff for knowledge of when and how to access this support. It was positive to see the PMM did take this step at the 45-Day visit.
- For Individual #201, examples of lack of reliable and valid data included:
  - There was no staff knowledge test to indicate staff awareness of psychiatric medication.
  - Training for delegated staff on use of glucometer was documented as occurring, but there was no evidence regarding if or how competency was validated.
  - It was not clear that new PBSP incorporated needed information from the PSP and history, as it was only documented that a new PBSP had been developed.
  - The PMM indicated staff were aware of supervision needs, but the CLDP did not provide a description of this in community settings,
  - Weight and vital signs were reported only as being monitored "frequently."

5. Individual #173 had not received some supports without sufficient justification having been provided. At the time of the 7-day visit, these included assistance with picking up his paycheck and receiving $20 in cash, and prompting to complete personal grooming and assistance with shaving. Non-receipt of the latter two supports had resulted in Individual #173 receiving a warning at work. At the 45

day, there were still supports determined to be not in place without sufficient justification being provided. These included the provider becoming representative payee, which was to have been in place within two weeks of transition, receiving $20 in cash, and having a monthly weight documented.

6. Based on the supports defined in the CLDP, the PMM correctly scored whether supports were correct based on the evidence for Individual #201. For Individual #173, some scoring was not considered to be accurate based upon the available evidence.

- One support was not scored correctly for both the 7- and 45-day PMM visits, based on the evidence provided. This support called for access to staff to assist him in gaining familiarity with new home and neighborhood. It was scored yes by the PMM, but data were not collected to substantiate the intent of the support was being fulfilled.
- There were two supports for staff to assist Individual #173 to contact friends. Both were marked yes at the time of the 7-day visit, even though the PMM noted correctly in the narrative these should be marked NA because Individual #173 had not requested to contact or visit those individuals. This appeared to be a clerical error. At the time of the 45-day, both were again marked yes, even though Individual #173 had still not made any requests. The PMM rightly noted at that time that this issue needed to be addressed in a post-move meeting in an effort to create a schedule to contact the two friends. This reflected an understanding that the intent of the support was to sustain and facilitate these important relationships, which had not been occurring. Scoring these two supports as having been provided was not an accurate reflection of the circumstances.
- Specific supports related to behavioral issues were scored as in place at the 45-day visit, but there were conflicting data that called into question whether there were emerging behavioral concerns that needed to be addressed. The additional questions section that follows the individual's specific supports in the PMM Checklist asked whether the records indicate behavioral incidents did not occur. This was scored as yes, apparently because Individual #173's record did not contain documentation of behavioral concerns, but the PMM interviewed a staff person who reported she had completed two or three incident reports related to behavioral incidents. The PMM did request copies, and this was still pending, however, this question should not have been scored in the affirmative based on the technicality that it was not in the record. Perhaps, as importantly, the PMM noted that the incidents were related to Individual #173 being upset about missing his family and no action was being taken to address this root cause, making it more likely for similar incidents to recur.

7. The PMM was generally diligent in both identifying and following-up on supports that were not being provided. Still, some needed follow-up did not occur in a timely manner, and for Individual #173, there was one concern that was identified, but not addressed.

- The PMM followed-up as needed after the 45 day visit regarding Individual #173 receiving the appropriate amount of money on a weekly basis and requesting that his weight be documented and provided. She accurately identified a need for follow-up regarding visits with two friends that had not occurred. She had also requested copies of behavioral incident reports, which was appropriate. Per the additional ISPA documentation requested for review, neither of these last two had been yet addressed by the IDT as of 8/15/16, or within 30 days, so this would not be considered timely. The PMM noted Individual #173 was asking about his family, expressing that he missed them and wanted to send money to his mother, but no follow-up action was indicated as being necessary. As noted above, this issue appeared to influence Individual #173's behavior as well.
- For Individual #201, there was generally good follow-up to all issues identified. It was noted the IDT did not meet until after 90-day visit to address the discontinuation of the SAMs program identified at the 45-day visit, so this was not considered to be timely.

8. For Individual #201, all issues related to identified supports had been followed up to resolution. For Individual #173, the IDT had met and resolved issues related to the identification of a psychiatrist, with the team agreeing that the Nurse Practitioner could provide the needed follow-up. All appropriate IDT members were involved in that determination. The establishment of Individual #173's bank account was still pending, but the PMM continued to provide needed follow-up. Follow-up was also still pending on behavioral incidents and setting a schedule for visiting with friends. As 30 days had elapsed since the identification of the need for follow-up and none had yet been documented, this indicator was scored as not meeting criterion at this time. The Monitoring Team also notes the issue regarding Individual #173's desire to see his family had been identified, but not addressed.

9-10. Post move monitoring did not occur during the week of the onsite review for these two individuals, but did occur and was observed for another individual, Individual #261 at her home. The PMM did a thorough job of obtaining evidence for the related supports (interview, observation, documentation). Her report corresponded with what was observed by the Monitoring Team.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.

Summary: No negative events occurred for either individual. This was very good to see. This important indicator will continue to be under active monitoring.

#	Indicator	Overall Score	173	201							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1							

Comments:
11. Neither Individual #173 nor Individual #201 had experienced any negative events.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.

Summary: This outcome focuses upon a variety of transition activities. San Antonio SSLC's APC, transition specialists, and PMM did a good job of working with the IDTs, families, community providers, and the local authority, as also evidenced by the many positive scores in the set of indicators below. Given the imminent change in the APC and PMM positions, these indicators, and all the indicators in this outcome, will remain in active monitoring.

#	Indicator	Overall Score	173	201							

12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	50% 1/2	0/1	1/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	100% 2/2	1/1	1/1							
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	100% 2/2	1/1	1/1							

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

- Updated with 45 days of transition: For Individual #173, 11 of 12 assessments made available for review were completed within 45 days of transition. The audiological assessment was completed on 2/8/16 and, while recent, was not updated as required. The pharmacy assessment was not included, but should have been updated particularly given that Individual #173 took psychotropic medication. For Individual #201, 11 of 13 assessments had been updated timely. Her audiological assessment was from 2014 and should have at least been updated to confirm the information in it was current. The nursing assessment was dated 1/5/16, which was more than 45 days prior to the transition date of 3/1/16.

- Assessments provided a summary of relevant facts of the individual's stay at the facility: For Individual #173, 10 of 12 assessments provided a sufficient summary. The social and psychiatric assessments did not meet criterion. The social assessment provided minimal information about family background and the psychiatric assessment provided no information about the PSP. For Individual #201, 9 of 13 assessments present provided a sufficient summary of stay. Those that did not meet criterion included medical and nursing assessments that did not provide any detail about the cause of the ER treatment that occurred in August 2015 requiring treatment with Narcan and potassium, the psychiatric assessment which had very little history and minimal description of psychiatric indicators, and the behavioral assessment that provided no discussion of history of self-injury.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: For Individual #173, seven of 12 assessments available provided a comprehensive set of recommendations. Those that did not included social, medical, nursing, psychiatric, and behavioral health. Pharmacy was not provided for review. For Individual #201, nine of 13 assessments provided a comprehensive set of recommendations. Those that did not included medical and nursing that did not address either needed ENT follow-up in one year or the need for a follow-up physician visit recommended to occur after B-12 levels were checked; psychiatry that offered only one recommendation to continue Zyprexa, but made no other recommendations regarding the PSP, psychiatry indicators or side effects of medications; and the behavioral assessment, which provided only broad recommendations to discontinue the PBSP and implement PSP and to continue follow-up with psychiatry quarterly. There was no recommendation regarding specific training needed on the PSP, who should be trained, with what methodology or how competency would be measured. It was again noted that the pharmacy assessment was missing.
- Assessments specifically address/focus on the new community home and day/work settings, and identify supports that might need to be provided differently or modified in a community setting: For Individual #173, eight of 12 assessments met criterion. Those that did not were medical, nursing, nutrition, and behavioral health. For Individual #201, nine of 13 assessments met criterion. Those that did not were medical, social work, behavioral, and psychiatric.

13. Both CLDPs met criterion for this indicator.

14. Community provider staff training was completed for both Individual #173 and Individual #201. Training for Individual #201's transition appeared to meet criterion, but there was insufficient documentation that facility staff provided training that met Individual #173's needs. It was determined at his CLDP that no further training was needed beyond the inservice provided for his pre-move visits to the home. Based on the assessments and supports, training should have been provided on risks for cardiac and medication side effects, behavioral triggers, and prompting for various and specific hygiene needs, including toothbrushing. Per the earlier training documentation provided for review, medication side effects and toothbrushing supports were not included.

15. For both Individual #173 and Individual #201, the CLDPs did not provide an adequate determination of the need for collaboration between facility staff and community clinicians. For Individual #173, there was no support for the physician or psychiatrist to collaborate with community counterparts regarding not challenging Zyprexa. For Individual #201, there was excellent collaboration between the facility nurse and Premient (provider) nursing staff. This was very good to see, but there was no evidence of other collaboration by medical staff, particularly related to her worsening CKD and impending hemodialysis. This latter appeared to be significant enough to merit discussion between the Center's medical staff and the community physician.

16. This indicator applies only as needed. The two CLDPs did not, but needed to, indicate that the IDT considered this transition activity, even if there was a determination that the activity was not needed for the individual.

17-18. SSLC, community provider staff, the LIDDA and others consistently engaged in activities to meet the needs of both Individual #173 and Individual #201. Examples included the collaboration among various agencies regarding employment and benefits counseling to support Individual #173's goal of second job. In addition to the collaboration between the facility and provider nurses for Individual #201 as detailed above, there was excellent collaboration among all parties (including DADS State Office) to ensure Individual #201's Medicaid would be active almost immediately after transition so that health care needs would be met.

19. Both met criterion for pre-move supports being in place in the community settings on the day of the move.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: Once referred, individuals received lots of attention regarding their transitions. Given the imminent change in the APC and PMM positions, this indicator will remain in active monitoring. With sustained performance, it is possible that it might move to the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall Score	173	201								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1								

Comments:
20. San Antonio SSLC had initiated Individual #173's referral and begun community exploration in a very timely manner after assisting him to obtain citizenship. Individual #201's transition took considerably longer from the initial referral date of May 2014, but thorough documentation indicated the delays were related to her own choices and/or intervening health concerns.

APPENDIX A – Interviews and Documents Reviewed

Interviews: Interviews were conducted of individuals, direct support professionals, nursing, medical, and therapy staff.

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, date of prior ISP, date current ISP was filed, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since the last review, with date of admission;
- Individuals transitioned to the community since the last review;
- Community referral list, as of most current date available;
- List of individuals who have died since the last review, including date of death, age at death, and cause(s) of death;
- List of individuals with an ISP meeting, or a ISP Preparation meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Lists of:
  - All individuals assessed/reviewed by the PNMT to date;
  - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
  - Individuals referred to the PNMT in the past six months;
  - Individuals discharged by the PNMT in the past six months;
  - Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
  - Individuals who received a feeding tube in the past six months and the date of the tube placement;
  - Individuals who are at risk of receiving a feeding tube;
  - In the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
  - In the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
  - In the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
  - In the past six months, individuals who have experienced a fracture;
  - In the past six months, individuals who have had a fecal impaction or bowel obstruction;
  - Individuals' oral hygiene ratings;
  - Individuals receiving direct OT, PT, and/or speech services and focus of intervention;
  - Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received;
  - Individuals with PBSPs and replacement behaviors related to communication;

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
    - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - In the past six months, individuals with dental emergencies;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
    - Crisis intervention restraints.
    - Medical restraints.
    - Protective devices.
    - Any injuries to individuals that occurred during restraint.
    - DFPS cases.
    - All serious injuries.
    - All injuries from individual-to-individual aggression.
    - All serious incidents other than ANE and serious injuries.
    - Non-serious Injury Investigations (NSIs).
    - Lists of individuals who:
        - Have a PBSP
        - Have a crisis intervention plan
        - Have had more than three restraints in a rolling 30 days
        - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
        - Were reviewed by external peer review
        - Were reviewed by internal peer review
        - Were under age 22
    - Individuals who receive psychiatry services and their medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Facility policies related to:
    a. PNMT
    b. OT/PT and Speech

    c. Medical
    d. Nursing
    e. Pharmacy
    f. Dental
- List of Medication times by home
- All DUE reports completed over the last six months (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results)
- For all deaths occurring since the last review, the recommendations from the administrative death review, and evidence of closure for each recommendation (please match the evidence with each recommendation)
- Last two quarterly trend reports regarding allegations, incidents, and injuries.
- QAQI Council (or any committee that serves the equivalent function) minutes (and relevant attachments if any, such as the QA report) for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.
- The facility's own analysis of the set of restraint-related graphs prepared by state office for the Monitoring Team.
- The DADS report that lists staff (in alphabetical order please) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- A list of any individuals for whom you've eliminated the use of restraint over the past nine months.
- A copy of the Facility's guidelines for assessing engagement (include any forms used); and also include engagement scores for the past six months.
- Calendar-schedule of meetings that will occur during the week onsite.

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months

- IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- AVATAR Immunization Record
- Consents for immunizations
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Direct Support Professional Instruction Sheets, and documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- To show implementation of the individual's IHCP, any flow sheets or other associated documentation not already provided in previous requests
- Last six months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last three months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- For individuals that have been restrained (i.e., chemical or physical), the Crisis Intervention Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing, Administration of Chemical Restraint Consult and Review Form, Physician notification, and order for restraint
- Signature page (including date) of previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one's signature page here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary, including periodontal chart, and signature (including date) page of previous dental examination
- For last six months, dental progress notes and IPNs related to dental care
- Dental clinic notes for the last two clinic visits
- For individuals who received medical and/or dental pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.
- For individuals who received general anesthesia/TIVA, all vital sign flow sheets, monitoring strips, and post-anesthesia assessments

- For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any individual with a dental emergency in the last six months, documentation showing the reason for the emergency visit, and the time and date of the onset of symptoms
- Documentation of the Pharmacy's review of the five most recent new medication the orders for the individual
- WORx Patient Interventions for the last six months, including documentation of communication with providers
- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable
- REISS screen, if individual is not receiving psychiatric services

The individual-specific documents listed below:
- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment

- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.

- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual's transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
ADL	Adaptive living skills
AED	Antiepileptic Drug
AMA	Annual medical assessment
APC	Admissions and Placement Coordinator
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
CBC	Complete Blood Count
CDC	Centers for Disease Control
CDiff	Clostridium difficile
CLDP	Community Living Discharge Plan
CNE	Chief Nurse Executive
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CXR	Chest x-ray
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DOJ	Department of Justice
DSHS	Department of State Health Services
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
ENT	Ear, Nose, Throat
FSA	Functional Skills Assessment
GERD	Gastroesophageal reflux disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin

HCS	Home and Community-based Services
HDL	High-density Lipoprotein
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
IDT	Interdisciplinary Team
IHCP	Integrated Health Care Plan
IM	Intramuscular
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IV	Intravenous
LVN	Licensed Vocational Nurse
LTBI	Latent tuberculosis infection
MAR	Medication Administration Record
mg	milligrams
ml	milliliters
NMES	Neuromuscular Electrical Stimulation
NOO	Nursing Operations Officer
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PDCT	Potentially Disrupted Community Transition
PEG-tube	Percutaneous endoscopic gastrostomy tube
PEMA	Psychiatric Emergency Medication Administration
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation

QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RDH	Registered Dental Hygienist
RN	Registered Nurse
SAP	Skill Acquisition Program
SO	Service/Support Objective
SOTP	Sex Offender Treatment Program
SSLC	State Supported Living Center
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus