United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

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

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

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

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

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at San 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. At the last review, 13 of these indicators were moved to the category of requiring less oversight. During this review three other indicators had sustained high performance scores and will be moved to the category of requiring less oversight. These were in the areas of incident management and included full outcome: incident management outcome 5.

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.

Restraint

The facility and the behavioral health services department attended to crisis intervention restraint since the last review and positive results were evident. Overall, the census-adjusted frequency of occurrence of crisis intervention restraint was on a decreasing trend over the nine-month period, was slightly lower than at the time of the last review, and was now the fourth lowest in the state. The average duration of a physical restraint was more than one minute less compared with the time of the last review, now at less than four minutes. The number of individuals with protective mechanical restraint for self-injurious behavior decreased from four to three, however, the individual was changed from categorization of PMR-SIB to protective supportive device (DADS policy #55). The state's restraint policy (DADS policy #01) requires that if a PMR-SIB transitions, it should be to medical restraint. The facility should research this further and ensure that all individuals who have protective supportive devices, medical restraints, and PMR-SIB are properly classified so that the proper protections (i.e., application, review, consent) are in place, too.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: timely completing and documenting nursing assessments, monitoring individuals for potential side effects of chemical restraints, providing follow-up

for abnormalities in vital signs, assessing individuals for injuries and documenting the results, and providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline.

Abuse, Neglect, and Incident Management

Overall, protection from harm indicators were being addressed. For instance, three new indicators were moved to the category of requiring less oversight. Supports were in place to reduce risk of abuse, neglect, exploitation, and serious injury as evidenced by nine of the investigations meeting all of the criteria. Most investigations met most criteria, but some did not meet criteria for correct reporting of an allegation, for ensuring proper protections were immediately put into place, and for timely completion of the investigation.

Quality improvement activities were occurring at San Antonio SSLC to reduce incidents. These included department-specific checklists to self-examine various aspects of incidents, and what was called a cultural campaign that focused attention on serious injuries, unauthorized departures, and restraints. The QAQI Council continued to meet each week, with a rotating schedule of weekly, monthly, and quarterly topics. Facility trend analysis regarding protection from harm data might be improved with assistance from the QA department.

Other

Some progress was seen regarding assessing need for pretreatment sedation and providing treatments or strategies are provided to minimize or eliminate the need for it.

The Center did not appear to have a system to ensure that potential adverse drug reactions (ADRs) were reported immediately, further investigated, and probability scales completed.

The Center had not completed at least quarterly drug utilization evaluations (DUEs). Several of the documents the Center submitted as DUEs provided good relevant clinical information and addressed systems issues that must be addressed. However, this information would not be considered to be a DUE. Follow-up also was needed for the findings of the two DUEs that the Center did complete.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.	
Summary: The facility and the behavioral health services department attended to crisis intervention restraint since the last review and positive results were evident, as indicated in the scores for both indicators. Some additional attention to the classification (and resultant requirements) of protective devices is needed as well as trended data regarding pretreatment sedation. Good progress was shown; both	Individuals:

indicators will remain in active monitoring.											
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	83% 10/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	82% 9/11	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments:
Comments:
1. Twelve sets of monthly data provided by the facility for the past nine months (July 2016 through March 2017) were reviewed. Overall, the census-adjusted frequency of occurrence of crisis intervention restraint was on a decreasing trend over the nine-month period, was slightly lower than at the time of the last review, and was now the fourth lowest in the state. The frequency of crisis intervention physical restraint followed the same pattern. Moreover, the average duration of a physical restraint was more than one minute less compared with the time of the last review, now at less than four minutes. This was in the middle compared with the other facilities. The frequency of crisis intervention chemical restraints was on a descending trend, with the most recent four months having three occurrences total. The frequency of crisis intervention mechanical restraints was zero.

There were few injuries that occurred during crisis intervention restraint, that is, to be specific, two non-serious injuries (scratches) in the nine-month period and the number of individuals who had a crisis intervention restraint each month was also on a decreasing trend from about 12 individuals to about five individuals. This compared with about nine individuals per month at the time of the last review.

The number of individuals with protective mechanical restraint for self-injurious behavior decreased from four to three, however, the individual was changed from categorization of PMR-SIB to protective supportive device (DADS policy #55). The state's restraint policy (DADS policy #01) requires that if a PMR-SIB transitions, it should be to medical restraint. The facility should research this further and ensure that all individuals who have protective supportive devices, medical restraints, and PMR-SIB are properly classified so that the proper protections (i.e., application, review, consent) are in place, too.

- Staff must have clear guidelines for use and monitoring of the device.
- Behavioral plans to address self-injurious behavior must continue to be implemented and monitored.
- IDTs must review the need for the device at least annually.

There were few occurrences (three) of chemical restraints for medical procedures, and there were no occurrences of non-chemical restraints for dental procedures. Trends regarding the frequency of the use of chemical pretreatment sedation for dental procedures could not be determined based upon the data presented.

Thus, facility data showed low/zero usage and/or decreases in 10 of these 12 facility-wide measures (overall use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; duration of physical restraint; restraint-related injuries; number of individuals who had crisis intervention restraint; use of PMR-SIB; use of pretreatment sedation for medical; and use of non-chemical restraints for dental procedures.

These positive results were the result, at least in part, of the facility-wide activities related to restraint management. One was what the facility called a cultural campaign that focused on three areas, one of which was restraint usage. Another was the restraint reduction committee. The committee was active for a number of years, reviewed lots of data, and engaged in thoughtful discussion. The behavioral health services director provided leadership for these activities.

2. Four of the individuals selected for review by the Monitoring Team were subject to restraint. The Monitoring Team also reviewed a restraint for each of two additional individuals. Of these six individuals, five received crisis intervention physical restraints (Individual #304, Individual #118, Individual #320, Individual #95, Individual #39) and one also received crisis intervention chemical restraint (Individual #186). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for four of the six (Individual #304, Individual #118, Individual #320, Individual #39). The other five individuals selected by the Monitoring Team had no restraints.

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: Four indicators were placed into the category of requiring less oversight after the last review and will remain so. The facility should ensure that proper consultation occurs prior to administration of crisis intervention chemical restraint (an infrequent occurrence at San Antonio SSLC). New staffing in the psychiatry department should result in increased performance in indicator 9. These five indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	304	118	320	186	95	39			
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.	86% 6/7	1/1	2/2	1/1	1/1	0/1	1/1			
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 5/5	1/1	2/2	1/1	N/A	N/A	1/1			
7	There was no injury to the individual as a result of implementation of the restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.										
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/2	Not rated	Not rated	Not rated	0/1	0/1	Not rated			
10	Restraint was used only after a graduated range of less restrictive	86%	1/1	2/2	1/1	0/1	1/1	1/1			

	measures had been exhausted or considered in a clinically justifiable manner.	6/7									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	86% 6/7	1/1	2/2	1/1	0/1	1/1	1/1			

Comments:
The Monitoring Team chose to review seven restraint incidents that occurred for six different individuals (Individual #304, Individual #118, Individual #320, Individual #186, Individual #95, Individual #39). Of these, seven were crisis intervention physical restraints, and two 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.

5-6. For Individual #95 12/24/16, the restraint checklist said SIB, but did not describe (even briefly) what she was doing (in behavioral terms). For Individual #39 12/3/16, the restraint checklist said that she was walking to the gate. The Monitoring Team accepted this because the crisis intervention plan detailed how this behavior led to imminent danger, however, even so, additional detail as to what was occurring that led to the restraint implementation would be better to include.

9. When criterion for indicator 2 is met, this indicator is not scored. That was the case for four of the six individuals. For the other two, many of the sub-indicators were met, however, the absence of consistent psychiatric services led to the indicator not meeting criteria. Given the newly hired psychiatrist and the anticipation of the hiring of second psychiatrist, this support is likely to improve for individuals over the next few months.

10. For Individual #186 3/7/17 (the sole crisis intervention chemical restraint reviewed by the Monitoring Team), there was no consultation as required prior to administration, the behavioral health services on-call staff was not notified.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.

Summary: This indicator was placed into the category of requiring less oversight after the last review and it will remain so. While onsite, however, the Monitoring Team spoke with various staff, all of whom were knowledgeable about restraint guidelines and the individual support strategies that were in place to avoid restraints when possible to do so.	Individuals:

#	Indicator	Overall Score									
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: Restraint monitors did not attend the restraint within the required 15 minutes for all restraints as they had been doing at the time of the last review. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	304	118	320	186	95	39			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	57% 4/7	0/1	2/2	0/1	1/1	0/1	1/1			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Comments: 13. In three restraints, the restraint monitor arrived, but 30-90 minutes after the restraint.											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: timely completing and documenting nursing assessments, monitoring individuals for potential side effects of chemical restraints, providing follow-up for abnormalities in vital signs, assessing individuals for injuries and documenting the results, and providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	304	118	320	186	95	39			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	0% 0/7	0/1	0/2	0/1	0/1	0/1	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	0% 0/7	0/1	0/2	0/1	0/1	0/1	0/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/7	0/1	0/2	0/1	0/1	0/1	0/1			
Comments: The crisis intervention restraints reviewed included those for: Individual #340 on 12/4/16 at 12:55 p.m.; Individual #118 on 11/26/16 at 6:40 a.m., and 1/24/17 at 11:55 a.m.; Individual #320 on 3/16/17 at 11:50 a.m.; Individual #186 on 3/7/17 at 4:37 p.m. (chemical); Individual #95 on 12/24/16 at 10:32 p.m.; and Individual #39 on 12/3/16 at 10:33 a.m.											

a. For three of the seven crisis intervention restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #340 on 12/4/16 at 12:55 p.m., Individual #186 on 3/7/17 at 4:37 p.m., Individual #320's restraint on 3/16/17 at 11:50 a.m., and Individual #95 on 12/24/16 at 10:32 p.m.

For two of the seven restraints, nursing staff monitored and documented vital signs. Some examples of concerns included:

- The flowsheet the Center provided for Individual #340 did not include any information for the hours surrounding the restraint episode.
- For Individual #320's restraint on 3/16/17 at 11:50 a.m., at 12:36 p.m., the flowsheet documented vital signs. The nurse noted that the individual's pulse, and respiratory rate were high. However, the next nursing IPN was dated 3/17/17, indicating that the nurse did not follow-up on the high vital signs.
- On 3/7/17 at 4:37 p.m., Individual #186 received a chemical restraint. Ativan has potential side effects that can include orthostatic hypotension. Based on the provided documentation, nursing staff did not follow-up to assess for this potential side effect.
- For Individual #95's restraint on 12/24/16 at 10:32 p.m., the restraint checklist provided consisted of only one page, and data related to the restraint was not found in the flowsheet or IPNs.
- For Individual #39's restraint on 12/3/16 at 10:33 a.m., initial nursing documentation showed the individual had an elevated blood pressure, but no follow-up was found in IView or nursing IPNs.

Nursing staff properly documented and monitored mental status of the individuals for none of the seven restraints. Statements such as "back to baseline," or "nurse checked mental status – yes" did not provide sufficient information. More details about the individuals' behavior at baseline, as well as before, during, and after the restraints were needed.

b. and c. As noted above, no nursing documentation was provided for two restraint episodes (i.e., for Individual #340, and Individual #95). For other restraints, initial documentation indicated potentially negative health effects, but nursing staff did not document follow-up (e.g., Individual #118 on 1/24/17 at 11:55 a.m., Individual #320 on 3/16/17 at 11:50 a.m., and Individual #39 on 12/3/16 at 10:33 a.m.). In other instances, from the documentation provided, it could not be discerned what specific steps nurses took to follow-up (e.g., Individual #118 on 11/26/16 at 6:40 a.m.). In addition, IPNs often could not be found to show nursing staff checked individuals for injuries post-restraint.

Of particular concern, for Individual #186's chemical restraint on 3/7/17 at 4:37 p.m., the Chemical Restraint Post-review, dated 3/8/17, noted: "it does not appear vital signs were obtained per protocol. The pharmacist, who documented the information also noted a B/P [blood pressure] of 95/64." In addition, nursing staff did not appear to repeat measurements or conduct follow-up. The Center did not provide any nursing IPNs or IView information to corroborate the vital signs the Pharmacist noted.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary:			Individuals:									
#	Indicator	Overall Score										
15	Restraint was documented in compliance with Appendix A.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments: 15. For Individual #95 12/24/16, specific information about level of supervision during the restraint was missing from the documentation.												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary:			Individuals:									
#	Indicator	Overall Score										
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.											
Comments: 16. Criteria were met, except there was no post-restraint ISPA for Individual #95 12/24/16. 17. Criteria were met, except one recommendation for Individual #186 3/7/17 was not implemented or provided with a rationale for no implementation (regarding spending more time with her family).												

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	186								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								
48	Multiple medications were not used during chemical restraint.	0% 0/1	0/1								
49	Psychiatry follow-up occurred following chemical restraint.	0% 0/1	0/1								
Comments:											

47-49. These indicators applied to a chemical restraint for one individual. The Administration of Chemical Restraint: Consult and Review was performed within the 10-day time frame. There was no documentation of psychiatric follow-up following the restraint episode.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.

Summary: San Antonio SSLC improved performance compared to the previous two reviews. Nine of the investigations met all of the criteria required by this outcome and indicator. This important indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	179	186	342	359	222	88	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	90% 9/10	1/1	1/1	2/2	2/2	1/1	1/1	0/1	1/1	

Comments:

The Monitoring Team reviewed 10 investigations that occurred for eight individuals. Of these 10 investigations, seven were DFPS investigations of abuse-neglect allegations (one confirmed, four unconfirmed, one streamlined and unfounded, one administrative referral). The other three were for facility investigations of a serious injury (fracture), a sexual incident, and a choking incident. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #294, UIR 17-004, DFPS 44761870, unconfirmed allegation of physical abuse, 9/14/16
- Individual #304, UIR 17-028, DFPS 44934456, unconfirmed allegation of neglect, 11/2/16
- Individual #179, UIR 17-034, DFPS 44948251 merged 44948280, unconfirmed allegation of neglect, 11/1/16
- Individual #179, UIR 17-030, sexual incident, 1/22/17
- Individual #186, UIR 17-022, DFPS 44916684, full referral of allegation of physical abuse, 10/25/16
- Individual #186, UIR 17-034, choking, thrusts, 2/5/17
- Individual #342, UIR 17-033, DFPS 44946130, unconfirmed allegation of neglect, 11/7/16
- Individual #359, UIR 17-096, DFPS 45149133, confirmed allegation of physical abuse 2/11/17
- Individual #222, UIR 17-143, DFPS, streamlined and unfounded allegation of physical abuse 3/20/17
- Individual #88, UIR 17-025, witnessed fracture, 12/31/16

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.

The facility made good progress in meeting these criteria. That is, all but one of the four sub-indicators were met for all of the investigations. For instance, background checks and signatory forms were done for all staff sampled by the Monitoring Team, various supports were in place that were related to the incident (e.g., PNMP, PBSP), and plans were implemented. The one exception was for Individual #222 UIR 17-143. His ISP talked about various actions to be taken to address his making false allegations. The plans were not thoroughly implemented. During the onsite review week, some changes were made to increase the likelihood of implementation. Individual #222 was the sole individual at San Antonio SSLC who was deemed a frequent reporter of false allegations.

Quality improvement activities were occurring at San Antonio SSLC to reduce incidents. One was initiated in December 2016: the quality assurance director provided department-specific checklists to seven facility departments for them to use to self-examine various aspects of incidents. Almost always, these were completed and sent back to the quality assurance director and eventually included in the investigation documentation. The other was what was called a cultural campaign. It focused attention on serious injuries, unauthorized departures, and restraints. The QAQI Council continued to meet each week, with a rotating schedule of weekly, monthly, and quarterly topics.

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

Summary: Performance was about the same as during the last review for this indicator. It is possible that clarifications in the UIR regarding reporting might be improved if there was an additional quality assurance check of this aspect of the UIRs before final submission. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	294	304	179	186	342	359	222	88	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	70% 7/10	1/1	0/1	1/2	2/2	1/1	1/1	1/1	0/1	

Comments:

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

Those not meeting 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 #304 UIR 17-028: The UIR stated that the allegation was reported to facility director/designee (by DFPS) on 11/1/16 at 10:26 pm. The DFPS report showed that the incident occurred at 3:50 am on 11/2/16 (reported to them at 3:53 am) and facility director notification was at 4:17 am. The UIR provided no insight on these confusing and conflicting pieces of information
- Individual #179 UIR 17-030: The UIR noted that, at 10:13 pm, the campus administrator was notified by a staff member, but due to absence of information in the UIR, the Monitoring Team could not validate that the staff member reported this within

one hour of receiving the self-report from Individual #179. The staff member was not interviewed.

- Individual #88 UIR 17-025: The incident occurred on 12/31/16 at 5:59 pm. The doctor ordered an x-ray for 1/1/17 in the am. The x-ray confirmed a fracture and the doctor ordered an ambulance to take Individual #88 to the hospital at 12:20 pm. The UIR noted that the injury was coded as serious at 12:26 pm and reported at 1:38 pm (more than 1 hour, though on page 9 it states 1:41 pm). Even so, at the time that the x-ray confirmed the fracture, the first staff aware of this (e.g., the doctor) it should have been reported to facility director/designee.

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: Indicator 3 will remain in active monitoring, in part, due to the need for improvement in reporting (indicator 2).

#	Indicator	Overall Score	Individuals: 294	304	179	186	342	359	222	88	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 1/1	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.										

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

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

Summary: Alleged perpetrator immediate re-assignment and appropriately conducted emotional assessments were not evident for all investigations. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	179	186	342	359	222	88	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	70% 7/10	1/1	0/1	2/2	2/2	1/1	0/1	0/1	1/1	

Comments:
6. While onsite, documentation was provided showing re-assignment of all alleged perpetrators for a number of the investigations. In the future, reassignment must be correctly and fully noted in the UIR because it is the official investigation report. For this review, the

Monitoring Team accepted alternate documentation showing reassignment date and time.

Three investigations, however, had other problems in providing immediate protections and, therefore, were scored as not meeting criteria:

- Individual #304 UIR 17-028: The alleged perpetrator was reassigned at the beginning of her subsequent work shift, not immediately after the allegation, which occurred mid-way through the previous work shift.
- Individual #359 UIR 17-096: An emotional assessment was done, but it was done by the nurse rather than by the behavioral health specialist, who has specific training in this area.
- Individual #222 UIR 17-143: There was confusing and conflicting information in the UIR. It looked like the allegation was on 3/20/17 and the alleged perpetrator was re-assigned on 3/22/17.

Outcome 5– Staff cooperate with investigations.

Summary: Staff cooperation was scored as meeting all criteria for all investigations for this review and for the last two reviews with one exception in October 2016. This indicator will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 294	304	179	186	342	359	222	88	
7	Facility staff cooperated with the investigation.	100% 10/10	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1	

Comments:

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.

Summary: Required elements of a thorough investigation were present for all of these investigations for this review and the previous two reviews (with one exception in November 2015), therefore, indicator 8 will be moved to the category of requiring less oversight. With sustained high performance, indicators 9 and 10 might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	179	186	342	359	222	88	
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	2/2	2/2	1/1	1/1	1/1	1/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	90% 9/10	1/1	1/1	1/2	2/2	1/1	1/1	1/1	1/1	
10	The analysis of the evidence was sufficient to support the findings	90%	1/1	1/1	2/2	2/2	0/1	1/1	1/1	1/1	

	and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	9/10									

Comments:

8. In general, the quality of facility-only investigations was very good. For example, for Individual #294 UIR 17-004, DFPS investigated the allegation of abuse/neglect. The facility did an investigation of the discovered serious injury. This was an excellent investigation that included extensive video review to try and determine how the injury occurred. Another example, Individual #186 UIR 17-034 was a very thorough investigation with detailed review and analysis of evidence.

9. For Individual #179 UIR 17-030, the staff member to whom Individual #179 reported the alleged incident was not interviewed. Despite this shortcoming (which could have validated timely reporting), this was a very thorough investigation with detailed review and analysis of evidence.

10. Individual #342 UIR 17-033, he was on enhanced/1:1 to minimize risk of re-injury to his repaired eye. His level of supervision was breached for three minutes and there was no re-injury, however, due to the potential for serious injury, this should have resulted in at least some questioning of the DFPS finding of unconfirmed.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: Investigations commenced appropriately but some were not completed with the required timelines and some did not have thorough supervisory review. Therefore, indicators 12 and 13 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	179	186	342	359	222	88	
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	70% 7/10	1/1	1/1	1/2	2/2	1/1	0/1	1/1	0/1	
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	70% 7/10	1/1	0/1	1/2	2/2	0/1	1/1	1/1	1/1	

Comments:

12. Three investigations did not meet criteria with this indicator:
    - For Individual #179 UIR 17-034, the incident occurred on 11/7/16 and the investigation was completed on 12/14/16. There were extension requests noting staff needed to be interviewed. The only attempts noted in the DFPS report were on 11/11/16 and 12/6/16.

- For Individual #359 UIR 17-096, there was an extension for more time to review video and identify any additional witnesses. The incident was reported on 2/11/17. The first staff interview occurred on until 2/28/17 (day 17). The investigation was completed on 3/3/17.
- For Individual #88 UIR 17-025, the incident occurred on 12/31/16. The investigation was completed on 1/13/17. The extension request was requested due to the number of unusual incidents that were not defined.

In a response to the draft version of this report, the State noted that it would not have granted extension requests if the requests had not met their standard. However, the State also noted that it would work with field offices to ensure that correct (i.e., more detailed) documentation is provided regarding the reasons for each extension request.

13. Supervisory review did not detect the missing or problematic aspects of three investigations. 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:			Individuals:								
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.										
Comments:											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.										
Summary: Recommendations were directly related to findings for all investigations for this review and the past two reviews, too. Therefore, indicator 16 will be moved to the category of requiring less oversight. Implementation of recommendations in a timely manner scored higher for both indicators 17 and 18 compared with the last review. With sustained high performance, both might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall	294	304	179	186	342	359	222	88	

		Score									
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	1/1	N/A	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	86% 6/7	N/A	1/1	1/1	2/2	0/1	1/1	N/A	1/1	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 4/4	1/1	N/A	N/A	2/2	N/A	N/A	N/A	1/1	
Comments: 17. For Individual #342 UIR 17-033, three of the four recommendations were implemented, though past their due dates. There was one occurrence of a confirmation of a physical abuse category 2. The staff member's employment was not maintained.											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. There was not much progress since the last review. This outcome and its indicators will remain in active monitoring. Assistance from the QA department would likely be helpful here.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	No									
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: 19-23. There was not much progress since the last review. Data were recorded and graphed, but it was incomplete in terms of the many areas required to meet criteria with these indicators. Narratives were primarily anecdotal statements with limited data and with limited comparative data to allow a determination of improvement or regression.											

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	0/1	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. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA need to be expanded and improved. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA, it is essential that such policies be developed and implemented.

For these two instances of the 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 a post-operative vital sign sheet was completed. In terms of medical clearance, Individual #88 did not have a form completed. For Individual #355, a note entitled medical clearance did not document an adequate perioperative evaluation. It did not address the risk of anesthesia or discuss medication management for the peri-operative period.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess this indicator.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									

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

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.												
Summary: Good progress was seen, especially regarding IDT review of the need for PTS. Although criteria for this indicator (1) were not met for Individual #166, four of the five sub-indicators met criteria. With sustained high performance, it is possible that indicators 3, 4, and 5 might be moved to the category of requiring less oversight. All six indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	166	320								
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	50% 1/2	0/1	1/1								
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 2/2	1/1	1/1								
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	100% 2/2	1/1	1/1								
4	Action plans were implemented.	100% 2/2	1/1	1/1								
5	If implemented, progress was monitored.	100% 2/2	1/1	1/1								
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	50% 1/2	1/1	0/1								

Comments:

1-6. This outcome and its indicators applied to Individual #166 and Individual #320. Individual #166's scoring is based on an ISPA dated 2/28/17 and an ISP dated 6/14/16. Individual #320's scoring is based on an ISPA dated 2/24/17.

1. There was evidence that Individual #320's IDT discussed 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 PTS versus with PTS. Additionally, there was informed consent from the LAR/Facility Director. Neither Individual #166's ISPA, nor his ISP, however, had evidence of informed consent.

2-5. The various criteria were met for these indicators, including determination of the need for a plan, development, and

implementation. This was all very good to see.

6. Individual #320 was not progressing on his 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: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	6	267	240	287					
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.	100% 4/4	1/1	1/1	1/1	1/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	100% 4/4	1/1	1/1	1/1	1/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	100% 4/4	1/1	1/1	1/1	1/1					
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:

- On 10/20/16, Individual #6 at the age of 48 died of cardiopulmonary arrest, and pancreatic cancer;
- On 1/24/17, Individual #267 at the age of 66 died of acute respiratory failure, and Influenza B;
- On 2/28/17, Individual #240 at the age of 56 died of squamous cell carcinoma of bladder; and
- On 3/5/17, Individual #287 at the age of 53 died of congestive heart failure, and mitral valve disease.

b. through d. The nursing and medical reviews of deaths generally identified relevant areas of need and offered recommendations to address them.

The QA Nurse identified specific areas in need of improvement. For example, findings included:
Annual Nursing Assessments were deficient in their analysis of and recommendations to address the individual's health risks and supports.

- Nursing documentation failed to show that nurses followed protocols/standards of care for the individuals' health problems, and followed through to resolution of the problems.
- Direct support professional instructions were deficient in relation to preventive and precautionary measures specific to the individuals' health conditions.
- Across disciplines, there was a lack of understanding and integration of processes related to end of life/hospice/pain management.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. As discussed in previous reports, Center staff need mechanisms to determine whether or not implementation of the recommendations results in changes in care and services provided to the individuals, and outcomes for individuals.

In addition, the documentation the Center provided indicated that many of the recommendations were in an "ongoing" status.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: The Center did not appear to have a system to ensure that potential adverse drug reactions were reported immediately, further investigated, and probability scales completed. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	ADRs are reported immediately.	33% 1/3	0/1	0/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	33% 1/3	0/1	0/1	1/1						
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	33% 1/3	0/1	0/1	1/1						
d.	Reportable ADRs are sent to MedWatch.	0% 0/2	0/1	0/1	N/A						

Comments: a. through d. Individual #277 experienced tachycardia that was likely due to albuterol and scopolamine. The potential ADR was reported timely, clinical follow-up was completed, and the Pharmacy and Therapeutics Committee thoroughly discussed it, including the results of the probability scale.

Two potential ADRs were not reported as such. These included: 1) Individual #166 had hyponatremia that was attributed to

medications, and there also was some discussion about medications being potentially related to pleural effusions; and 2) Individual #186 had hyponatremia that was associated with psychotropic medications.

An ADR form should be completed for any suspected ADR. They should then be further investigated and probability scales completed. Based on the probably score, a suspected ADR should then be classified as doubtful, possible, probable, or definite.

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 had not completed at least quarterly DUEs. Several of the documents the Center submitted as DUEs provided good relevant clinical information and addressed systems issues that must be addressed. However, this information would not be considered to be a DUE. Follow-up also was needed for the findings of the two DUEs that the Center did complete. These indicators will remain in active monitoring.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	33% 2/6
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2

Comments: a. and b. Since the last review, San Antonio SSLC completed two actual DUEs, as well as four other studies that did not meet the definition of a DUE, although these studies provided good relevant clinical information and addressed systems issues that must be addressed. The two actual DUEs were not timely based on the requirement for at least quarterly DUEs (i.e., October 2016 and March 2017). These DUEs and studies included:

- On 10/13/16, a DUE was presented to the Pharmacy and Therapeutics (P&T) Committee on levothyroxine and follow-up thyroid stimulating hormone (TSH). The purpose of the DUE was to determine compliance with monitoring parameters for levothyroxine following dosage change. Seventy-two individuals were identified (31.3% of population). The conclusion of the DUE was: "Compliance with recommended follow-up for levothyroxine dosage changes is poor." This was a disconcerting finding that speaks to the effectiveness of the Pharmacy Department's Intelligent Alert System. The Pharmacy is responsible for ensuring that the appropriate orders are written for a follow-up TSH at the time the prescriber writes a medication change. The recommendation was for Pharmacy to assist the PCPs to obtain follow-up TSH, when possible. That system is currently in place in the form of the Intelligent Alerts, but clearly is not effective. Sufficient follow-up had not occurred.
- In March 2017, a DUE was completed related to compliance with lithium lab monitoring. Fourteen individuals had active lithium orders. The compliance rate for lab monitoring was 64.3%. The conclusion was that the majority of the late lithium levels were associated with procedures related to implementation of the new electronic health record. It was unclear what the plan was to correct this serious issue.
- In August 2016, a study was completed on blood pressure measurements. The objective of this evaluation was not clearly stated. However, the study indicated problems with obtaining consistent and accurate blood pressures measurements. As

recommended, it would appear appropriate to develop a protocol for obtaining blood pressure measurements.

- In November 2016, a study was conducted on fish oil and cachexia. The goal of this study was to determine if treatment with fish oil reverses weight loss associated with cachexia. There were only two individuals identified as receiving fish oil during the study period. There might be value in reviewing data for these two individuals, but, as the study concluded, there were insufficient data to identify treatment effects.
- In November 2016, a study was completed on nasal medications. The objective was: "With the initiation of facility pharmacy services it is now possible to track utilization of bulk medications to determine if they are being utilized appropriately." The study concluded that the correct dose of nasal medication was not administered in 42% of the encounters. The recommendation was to consider discontinuing underutilized medications and repeat the evaluation in six months. Discussions with the Pharmacy Director indicated that there were concerns with their bulk medications, such as constipation medications and respiratory medications. The Monitoring Team identified irregularities in respiratory medications for one of the individual reviewed. It would appear that there was a need to proceed with reviewing other areas of concern relative to the issue of bulk medications.
- On 3/26/17, a study was presented to the P&T Committee on HMG CoA reductase inhibitors (i.e., statins) and cardiovascular risk. This study was conducted to determine if the Center was in compliance with the 2013 American Heart Association and the American College of Cardiology guidelines on the treatment of cholesterol to minimize cardiovascular outcomes. The conclusion was that the Center had an opportunity to align current practice with the current national guidelines. Individuals at high risk without treatment should have treatment initiated or a clear rationale should be provided as to why treatment was not initiated. Low risk individuals currently treated with a statin should have their therapy challenged to determine if continued treatment was warranted. Follow-up would have occurred after the deadline for the document request submission.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the last review, 15 of these indicators were moved the category of requiring less oversight. For this review, three other indicators were moved to this category, in psychology/behavioral health and skill acquisition plans.

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

Assessments

For more than half of the individuals (same as at the last review), the IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP. None of the IDTs, however, arranged for and obtained all of the needed, relevant assessments prior to the annual meeting. Further, throughout the year, IDTs did not meet to discuss lack of progress and address barriers or revise supports (though they did meet when there were behavioral or medical problems).

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. As a result, for all of the risk ratings reviewed, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

It was positive that most individuals reviewed had timely annual medical assessments. However, significant improvement was needed with regard to the quality of the annual medical assessments.

In addition, PCPs should review the individuals' health status at least every six months, or more often as needed. More specifically, based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs should define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. Some of these standards of practice are defined in Appendix entitled "Disease-Specific Standards of Care." Plans of care in AMAs should define the frequency of review by PCPs as well as consultants, and these reviews should be included as action steps in IHCPs. Then, PCPs need to implement them at the frequency necessary to address individuals' needs.

Since the last review, improvement was noted with regard to the timely completion of annual dental exams. Although it appeared the dental summaries were timely, some were not signed and it was unclear who completed them (e.g., the dentist or the Registered Dental Hygienist). The Center should continue to focus on improving 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.

It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. Since the last review, some improvement was seen with regard to timely referral of individuals to the PNMT, and timely completion of the PNMT initial review. The Center should focus on continuing its progress in these areas, as well as improving referral of all individuals that meet criteria for PNMT review, completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT comprehensive assessments.

The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. The quality of OT/PT assessments continues to be an area on which Center staff should focus.

Much work was needed with regard to the quality of communication assessments, and particularly, the assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services.

The psychiatry department had a new full time psychiatrist on staff. Along with the competent and experienced psychiatry department RNs and support staff it is likely that various assessments, updates, and psychiatry-related goals will meet criteria at the time of the next review. There were, however, some improvements in the documentation for consent for psychotropic medications.

Behavioral health services maintained good performance in many areas. For instance, annual behavioral assessments, functional assessments, and PBSPs continued to be consistently timely and their content complete. The PBSP data system, which was excellent at the last Monitoring Team visit, was now not adequately measuring target and replacement behaviors. The behavioral health services department, however, had a reasonable plan to address this data problem.

Individualized Support Plans

The development of individualized, meaningful personal goals was not yet at criteria, but much progress was evident. All six ISPs, for instance, included one or more goals that met criteria (that is, in leisure, relationships, work/day, and independence, but not yet in the IHCP/health/wellness area, or in community living options). More than half were written in measurable terms, also demonstrating good progress. Unfortunately, just one was implemented sufficiently, correctly, and with adequately collected data to determine progress. QIDP monthly reviews included little meaningful information regarding progress towards goals and efficacy of supports.

Participation by all team members in the development of the ISPs was good; the exception being psychiatry (due to staffing problems in the department). The facility had several new QIDPs. Interviews with some of the new QIDPs indicated that they were knowledgeable regarding supports, services, and risks for individuals whom they were assigned to support. A majority of direct support professionals interviewed by the Monitoring Team were also very knowledgeable about the individuals.

San Antonio SSLC had skill acquisition plans for every individual and they were measurable. The facility recently implemented the new SAP pilot project to improve the quality of SAP development and implementation. The new format appears to address the concerns raised in this report regarding the quality of content and the components and quality of review (i.e., data based decisions to continue, discontinue, or modify SAPs) of the SAPs. For the most part, individuals were attending day programming and engaged throughout the day.

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: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but much progress was evident as described below. All six ISPs, for instance, included one or more goals that met criteria, and two ISPs had goals that met criteria in five of the six areas, for a total of 18 goals that met criteria. This was very good progress since the last review. Further, 12 of these 18 goals were written in measurable terms, also demonstrating good progress. Unfortunately, but one was implemented sufficiently, correctly, and with adequately collected data to determine progress. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall	186	166	342	179	119	355			

		Score									
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	2/6	3/6	1/6	4/6	4/6	4/6			
2	The personal goals are measurable.	0% 0/6	0/6	2/6	0/6	4/6	2/6	4/6			
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	1/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #186, Individual #166, Individual #342, Individual #179, Individual #119, Individual #355). 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. In addition, ISP annual or preparation meetings were observed for three individuals, facilitated by each of the facility's three ISP meeting facilitators. During each meeting, they prompted IDT members for goals, related activities, and action plans. Their facilitation actions appeared to play a role in the high level of participation from IDT members during the meetings.

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.

None of the six individuals had individualized goals in all six areas, however, there was improvement in the development of individualized goals based on preferences.

For these six individuals, the IDT had defined some personal goals that met criterion for being individualized based on the individual's preferences and strengths. Overall, 18 of 36 personal goals met criterion for this indicator. This was an improvement from the past review when five of 36 goals met criterion. IDTs particularly struggled with writing individualized day/work/vocational and health care goals. Goals that met criterion were:

- Individual #186's goals for relationships and living options.
- Individual #166's goals for leisure/recreation, greater independence, and living options.
- Individual #342's goals for leisure/recreation.
- Individual #179's goal for leisure/recreation, relationships, employment, and greater independence.
- Individual #119's goals for leisure/recreation, relationships, day/employment, and greater independence.
- Individual #355's goals for recreation/leisure, relationships, greater independence and living options.

Although IDTs had created the above goals (ones that were more individualized and based on known preferences), few had been fully

implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The facility needs to focus on barriers that are preventing individuals from achieving their goals and develop plans to address those barriers.

Examples of goals that did not meet criterion because they were not aspirational, individualized, and/or based on preferences included:

- Individual #186's work/day goal to remain on task and her greater independence goal to complete her activities of daily living.
- Individual #166's IDT did not develop a relationship goal and his employment goal to increase program attendance addressed compliance, but no skill building based on his preferences.
- Individual #342's employment goal to go to work was also based on compliance rather than skill building. His goal to brush his teeth was something that he was already doing and not aspirational. His relationship goal to swing with preferred staff was unlikely to lead to new relationship or build relationship skills.
- Individual #179's living option goal to live at San Antonio SSLC was not aspirational.
- The IDT did not develop a living option goal for Individual #119.
- Individual #355's day/vocational goal to complete a work task was not based on an adequate assessment process to determine his work preferences.

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

Twelve of the 18 personal goals that met criterion for indicator 1 also met criterion for measurability. This was another sign of progress for the QIDPs and IDTs.

The goals that were not measurable included:

- Individual #186's relationship goal to make a friend in the home and her living option goals to live in the most integrated setting.
- Individual #166's recreation/leisure goal to attend an indoor/outdoor gym to play sports.
- Individual #342's recreation/leisure goal to swing on swings and other rides.
- Individual #119's recreation/leisure goal to attend Beatles Day and relationship goal to make a friend at the library.

3. For the 12 goals that were determined to be measurable, only one had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals (Individual #166's greater independence goal). As noted throughout this report, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals due to the lack of data and documentation provided by the facility. It appeared that few action plans were regularly implemented.

The facility reported that QIDPs and other team members were participating in additional training offered by the state office on ISP development. The training was focused on assessments, SAP development, and overall implementation. Hopefully, this will assist the IDTs in developing more functional goals that will support individuals to learn new skills based on their preferences.

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. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators refer to the full set of action plans. That is, the qualities that are being monitored by these indicators may be evident in different action plans within the set of goals and action plans for the individual. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	186	166	342	179	119	355			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	1/6	0/6	2/6	2/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	67% 4/6	0/1	1/1	1/1	0/1	1/1	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	1/1	0/1	0/1	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	0/1	0/1	0/1	1/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	1/6	0/6	0/6	1/6	0/6			

Comments:

8. Some personal goals did not meet criterion in the ISPs, as described above in indicator 1, therefore, those action plans could not be evaluated in this context. A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

Overall, IDTs were struggling with developing action plans that supported accomplishment of goals. Action plans (and skill acquisition plans) often did not relate to the goal or were not specific enough to ensure consistent implementation and measurement of progress. The QIDP Coordinator indicated that IDTs were receiving further training and mentoring on the action plan development process.

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

- Individual #166's action plans to support his greater independence goal.
- Individual #179's action plans to support her recreation and work/day goals.
- Individual #119's action plans to support her work/day and greater independence goals.

9. Four of six ISPs integrated preferences and opportunities for choice in the individuals' ISP action plans. Individual #186 and Individual #179's ISPs did not integrate opportunities to make choices and have some control over their day.

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

The facility's self-advocacy committee was meeting twice per month. The Monitoring Team attended the meeting during the onsite week, as it usually does. This time, the meeting was better attended, more organized, and had more participation than any committee meeting observed over the past few years. Self-advocacy meeting can be one type of opportunity for individuals to work on decision-making and problem-solving skills.

11. Two individuals had action plans to support greater independence in a meaningful way. Individual #186 and Individual #166's greater independence goals focused on compliance with tasks rather than skill building. Individual #179 had a cooking goal with no related action plans. Individual #119's SAP to request batteries for her VOC and use a switch to activate her radio had been continued from her previous ISP. Without addressing barriers to progress, it was unlikely that her action plans would lead towards greater independence.

12. IDTs did not fully integrate strategies to minimize risks in ISP action plans. Specific support strategies should be included in staff instruction for implementing action plans, when relevant, to minimize risks in all settings. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. Some examples where strategies were not integrated in the ISP included:

- Individual #186's supports to address her risks for falls, SIB, and polypharmacy were not integrated into her action plans for

leisure/recreation, work, or greater independence.

- Individual #166's respiratory risk and risk for polypharmacy were not clearly identified or addressed in an integrated fashion.
- Individual #342's behavioral supports were not integrated into his recreation/leisure or vocational action plans.
- Individual #179's psychiatry supports were not integrated into her ISP action plans.
- Individual #119's positioning and mobility supports were not integrated into her ISP action plans for day programming and attending events in the community. Her behavioral and psychiatric supports were also not integrated in to ISP action plans.
- Individual #355 had action plans to address specific risk, including behavior and mobility. These supports were not integrated into action plans for employment and community outings.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In particular, psychiatry supports were rarely integrated into support plans developed by other disciplines. There were some examples of good integration between disciplines. For example, Individual #342's IDT considered integration of behavioral and communication supports in developing a communication device to offer him opportunities for more control over his day. In addition to the examples in indicator 12, other examples where disciplines needed to further integrate supports:

- For Individual #166, the IDT had not considered the impact of psychotropic medications on his respiratory risks.
- For Individual #119, communication supports had not been integrated into other action plans.
- Individual #355's action plans to go out and eat did not integrate mobility and communication strategies.

14. Meaningful and substantial community integration was absent from the ISPs.

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 #179's IDT had developed goals for her to work and live in the community based on her preferences. Action plans to support these goals, however, had not been implemented and barriers to implementation not addressed by the IDT. Overall, vocational/day assessments were not adequate for determining preferences. For example:

- Individual #186's employment goal referenced her place of employment and compliance issues, but not her preference for work. Her vocational assessment did not include an employment vision. It did note that she had been employed in the community in the past, however, did not identify whether or not that was a successful placement.
- Individual #166's vocational assessment did not explore possible work preferences beyond the contracts that he already worked on. His assessment also focused on compliance issues rather than preferences.
- Individual #342's ISP did not include a discussion of his vocational preferences.
- Individual #355's IDT also failed to consider further vocational assessment to explore possible preferences and new skill building opportunities related to employment.
- Individual #119's ISP noted that she was not interested in work and preferred to attend a retirement program. It was not evident that an adequate assessment had been completed to explore vocational interest or new skill building opportunities related to employment.

16. Although attendance at day programming had improved, none of the ISPs supported substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. As noted

for indicator 1, two individuals (Individual #179, Individual #119) had day/employment goals based on their known skills and preferences. Action plans to support these goals were not specific enough to ensure functional engagement throughout the day. Individuals did not have action plans to support sufficient functional, skill building opportunities, particularly in relation to developing functional work skills and supporting community integration.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Most notably, barriers to consistent implementation of action plans were not addressed.

18. Some action plans described detail about data collection and review, however, overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated and, in many cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented.

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

Summary: Overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. That being said, improvements were seen in the identification of individual's preferences (indicators 19 and 20) as well as in identifying obstacles to referral and putting plans in place (indicators 24, 25, and 26). With sustained high performance, indicator 24 might be moved to the category of requiring less oversight after the next review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 186	166	342	179	119	355			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	83% 5/6	1/1	1/1	0/1	1/1	1/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	100% 2/2	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.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	0/1	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	100% 5/5	1/1	N/A	1/1	1/1	1/1	1/1			

	community).										
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 2/2	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.	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	50% 1/2	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	0% 0/4	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. Five of six ISPs included a description of the individual's preference and how that was determined. The exception was Individual #342. His ISP noted that his preferences were unknown. The ISP did not include preferences in his current environment.

20. The Monitoring Team observed two annual ISP meetings, for Individual #345 and for Individual #333. For Individual #345, each IDT member stated his or her opinion and why, which included statements about what Individual #345 liked in an environment. For Individual #333, the IDT talked at length about him moving someday, maybe in the next two years, to live with a long-time staff member with whom he had an excellent relationship and how that environment had characteristics that were desirable to Individual #333.

21. One of the six ISPs fully included the opinions and recommendation of the IDT's staff members. Four individuals did not have input from the psychiatrist on the team. Documentation was not clear regarding discipline determination and recommendations in Individual #355's ISP

22. Five of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. The opinion of Individual #119's LAR was not included in the team's decision.

23. Two of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #186, Individual #166, Individual #342, and Individual #119's ISPs did not clearly define their living preferences and/or what supports could/could not be provided in the community.

24. Five of five ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed.

25. For Individual #345, most IDT members were ready to refer, however, her LAR did not want to move forward with a referral. The LAR's preference was identified as the reason for no referral. For Individual #333, there really weren't any obstacles to referral at this

point, other than it would be about two years until the staff member was ready for Individual #333to move with him. This was an excellent option, according to the team, one that was worth waiting for.

26. Two of the six individuals (Individual #166, Individual #342) had individualized, measurable action plans to address obstacles to referral or transition, if referred. For the most part, action plans were not measurable, as noted above. Individuals had broad based general action plans to participate in group home tours or attend provider fairs.

27. No plans were developed for Individual #345. Some plans were developed for Individual #333, related to spending time with the staff member at his home over the next year.

28. None of the ISPs included specific action plans to educate individuals on living options when relevant. Individual #186 and Individual #179 had recently lived in the community and were already familiar with living options.

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

Summary: ISPs were revised annually; with sustained high performance, indicators 30 and 31 might be moved to the category of requiring less oversight after the next review. More focus is needed to implement the many plans that are part of the ISP. This set of indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 186	166	342	179	119	355			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	50% 3/6	1/1	0/1	0/1	1/1	1/1	0/1			
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. ISPs were developed on a timely basis.

32. Documentation was not submitted that showed that all action plans were implemented on a timely basis for any of six ISPs. Examples in which timeliness criteria were not documented included:

- QIDP monthly reviews indicated that data had not been regularly available for Individual #186's action plans to support greater independence and living option goals.
- Data were not submitted for Individual #166 prior to January 2017. Monthly reviews from January 2017 through March 2017 did not support consistent implementation of all goals.
- Individual #342's March 2017 monthly review indicated that his relationship goal was not implemented within 30 days of ISP development.
- Individual #119's relationship goal from her 11/15/16 ISP had not been implemented as of March 2017.
- Data to confirm implementation of action steps were not available for any of Individual #355's goals.

33. Three of six individuals participated in their ISP meetings. Individual #166, Individual #342, and Individual #355 did not attend their annual ISP meetings.

34. Overall, attendance at annual ISP meetings by IDT members had improved. None of the individuals, however, had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Psychiatry participation in the IDT process was not evident in any of the ISPs (due to turnover in the psychiatry department over the past nine months).

QIDPs were knowledgeable regarding supports and services included in the ISP, which was good to see, however, it was not evident that all team members actively reviewed, monitored, and revised supports in a timely manner.

Outcome 6: ISP assessments are completed as per the individuals' needs.

Summary: Performance remained the same as last time for both indicators, both below criteria. A full set of assessments is needed for the IDT to thoroughly complete its work. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	186	166	342	179	119	355			
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	0/1	0/1	1/1	1/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

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 of six individuals.

- For Individual #186, the QIDP assessment summary indicated that the psychiatry assessment was not applicable. Her ISP indicated that she received psychiatry services, however, her assessment information was not available for review by the IDT.
- Individual #166's IDT did not consider the need for an updated vocational assessment.

36. None of the IDTs arranged for and obtained needed, relevant assessments prior to the IDT meeting. Without relevant assessments available to IDTs prior to the annual ISP meeting, it was unlikely that all needed supports and services were included in the ISP. Assessments that were either not submitted or submitted late included:

- For Individual #186, documentation indicated that a recommended EKG had not been completed. Her mammogram was also overdue.
- For Individual #166, his psychiatric assessment was not updated prior to the ISP meeting.
- Individual #342 and Individual #179's last comprehensive psychiatric exams were completed in 2014.
- Individual #119's nursing assessment was missing key information to help the team adequately identify risk status.
- Individual #355's nursing assessment was incomplete. Her PSI and psychiatry assessment were not submitted prior to the ISP meeting.

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

Summary: The need for conduct of monthly reviews was evident. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 186	166	342	179	119	355			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs met often in response to incidents and medical issues, but much less frequently to review progress or revise supports and services. When recommendations were made or supports were revised, IDTs rarely met again to ensure recommendations were implemented. Reliable and valid data were often not available to guide decision-making. As noted throughout this report, little progress was made towards achieving personal goals.

For all individuals, the IDTs did not meet to discuss lack of progress and address barriers or revise supports. When additional assessments were completed during the ISP year, there was rarely documentation that the team met to discuss recommendations from the assessment or assess the efficacy of revised supports. For example,

- Individual #186 had numerous falls over the ISP year. The team did not meet to thoroughly review supports and protections related to falls. Action plans were not consistently implemented and the team did not meet to address barriers to implementation.
- Individual #166's IDT did not meet following his hospitalization in January 2017 to review supports or following his consultation with the pulmonologist in February 2017 to review recommendations. The team also failed to meet when action plans were not consistently implemented. Monthly reviews were not timely and follow-up to issues not documented.
- Individual #342's goals were not regularly implemented and barriers to implementation were not addressed by the IDT. Per staff interviews, Individual #342 refused to consistently use his communication system. The team did not meet to reassess his

communication supports and revise if recommended.

- Individual #179, Individual #119, and Individual #355's QIDP monthly reviews indicated that action plans were not regularly implemented. The IDTs have not addressed barriers to implementation.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals. There was no evidence that IDT members were monitoring supports and services or took action when plans were not implemented.

The facility had hired several new QIDPs. Interviews with some of the new QIDPs indicated that they had received training on the ISP process and were knowledgeable regarding supports, services and identified risks for individuals whom they were assigned to support.

QIDP turnover had likely contributed to the inconsistency in documentation and review. QIDP monthly reviews included little meaningful information regarding progress towards goals and efficacy of supports. When additional assessments were recommended throughout the ISP year, if was often not apparent that the IDT obtained those assessments, reviewed any resulting recommendations, and/or implemented changes to supports when recommended.

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

Outcome 1 – Individuals at-risk conditions are properly identified.

Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 186	166	277	355	88	194	287	305	119
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.	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 specific risk areas [i.e., Individual #186 – circulatory, and constipation/bowel obstruction; Individual #166 – respiratory compromise, and weight; Individual #277 – gastrointestinal (GI) problems, and skin integrity; Individual #355 – constipation/bowel obstruction, and falls; Individual #88 – GI problems, and skin integrity; Individual #194 – dental, and GI problems; Individual #287 – fractures, and infections; Individual #305 – constipation/bowel obstruction, and seizures; and Individual #119 – respiratory compromise, and weight].

a. None of the IDTs effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines.

b. It was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate.

Psychiatry

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

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

Individuals:

#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
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 were not integrated into the overall treatment plan. Specifically, while goals were found in the psychiatric clinical documentation for some individuals, they were not included in the IHCP. There was a need to ensure that goals are integrated. The facility psychiatric staff will need to identify psychiatric symptoms for monitoring and develop goals regarding reductions in psychiatric symptoms. 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 for quarterly clinical encounters did not document the review of available data.

- To reiterate, there need to be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status.
- The goals need to be measurable, have a criterion for success, be presented to the IDT… appear in the IHCP, and be

tracked/reviewed in subsequent psychiatry documents as well as be part of the QIDP's monthly review.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: The absence of consistent psychiatric staffing at San Antonio has been a long-standing problem, often competing with the facility's ability to conduct various important activities, such as ensuring CPE content. With the hiring of a new full time psychiatrist, this (and other) outcomes and indicators might show improvement. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	291	118	179	166	320	186	342
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.	33% 3/9	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	0% 0/3	N/A	N/A	N/A	N/A	0/1	N/A	0/1	0/1	N/A
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.	44% 4/9	0/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1

Comments:

12-13. Individual #294 did not have a CPE.

14. The Monitoring Team looks for 14 components in the CPE. Three evaluations were complete and addressed all of the required elements. Six evaluations were lacking sufficient information in one to four required elements. The most common insufficient element was the inclusion of laboratory examinations.

15. For the three individuals admitted since 1/1/14, one individual, Individual #179, had a CPE completed within 30 days of admission, but no note from nursing. The record regarding Individual #320 included an IPN from nursing and primary care authored on the date of admission. The CPE was not completed for a year after admission. The record regarding Individual #186 included a CPE performed in July 2014, but the day of the evaluation was not noted. There was no IPN authored by primary care within the required time limit.

16. There were five individuals whose documentation revealed inconsistent diagnoses: Individual #166, Individual #320, Individual #342, Individual #186, and Individual #294.

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. This outcome and its indicators should be a focus of the psychiatry department; all indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
17	Status and treatment document was updated within past 12 months.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
17-18. Nine individuals required annual evaluations. None were done.

19. In eight cases, there was a psychiatric quarterly performed within 90 days of the ISP, therefore, this information was available to the ISP team within the required time frame. The ISP documentation should make this explicit in the future.

20. The psychiatrist or a member of the psychiatric team did not attend the ISP meetings.

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.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
Summary: It was good to see that one case met criteria. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342

22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. One individual, Individual #294, had a psychiatric support plan. The plan included information regarding the purpose of the plan, the symptoms to monitor for this individual, instructions for staff regarding recording data, and instructions for staff regarding how to respond to this individual when she experienced specific symptoms.

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

Summary: With sustained high performance, indicators 28, 29, and 32 might be moved to the category of requiring less oversight after the next review. Attention, however, needs to be paid to some of the content of the consents as required by indicators 30 and 31. All five indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	291	118	179	166	320	186	342
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	89% 8/9	1/1	0/1	1/1	1/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
28. One individual, Individual #304, was missing a consent form for an antidepressant medication. The facility had identified the lapse and had implemented corrective action to address the missing form. The facility's ability to self-monitor in this situation was positive to see.

29. The facility psychiatry staff had made great strides with including medication side effect information on the consent forms. The information included common and serious/rare side effects. While some technical terms were utilized, the terms were then restated in terms likely understandable by a layperson.

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

31. The examples did not include individualized alternate and non-pharmacological interventions.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Goals/objectives were based upon assessments for all individuals for this review and the past two reviews, with but one exception in November 2015. Therefore, indicator 4 will be moved to the category of requiring less oversight. Problems with data collection accuracy/reliability resulted in 0% scores for indicator 5, which will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.	100% 8/8	N/A	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.	0% 0/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

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

5. All individuals had interobserver agreement (IOA) and data timeliness data that indicated that the data were reliable. But even so, Individual #304, Individual #320, and Individual #342's progress notes indicated that their behavioral analysts questioned the reliability of target behavior data.

Additionally, the data collection system for all individuals' target and replacement behaviors had recently been changed to a system where staff were only required to record data once a shift, which several staff indicated had resulted in a decrease in the recorded frequency of target behaviors for several individuals. Therefore, all individuals' PBSP data were judged to be unreliable.

Ensuring the reliability of target behaviors should be a primary focus of the behavioral health services department. The department had utilized effective PBSP data collection systems in the past, and the Monitoring Team is optimistic that they can ensure the reliability

of these data again.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
Summary: Performance improved to 100% for indicator 10. This was good to see. With sustained high performance, it might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
10	The individual has a current, and complete annual behavioral health update.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
12	The functional assessment is complete.										
Comments: 10. All individuals had current and complete annual behavioral health updates											

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: These indicators maintained and/or showed steady improvement compared with the last two reviews. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	88% 7/8	N/A	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	The PBSP was complete, meeting all requirements for content and quality.	88% 7/8	N/A	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
Comments: 13. Seven individuals' PBSPs were implemented within 14 days of attaining consents. The exception was Individual #304's PBSP. 15. All but one PBSP was complete in content. The exception was Individual #320's PBSP. Individual #320's most recent functional assessment identified tangible reinforcers as a maintaining variable for several target behaviors. His PBSP did not, however, address or discuss the role of tangible reinforcers.											

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

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: It was positive that most individuals reviewed had timely annual medical assessments. Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur at a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Significant improvement was needed with regard to the quality of the annual medical assessments. In addition, the Center needs to define the frequency of interval medical reviews in individuals' IHCPs, and PCPs need to implement them at the frequency necessary to address individuals' needs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. Problems varied across medical assessments the Monitoring Team reviewed. The Center only provided four of 10 pages of Individual #194's AMA. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed past medical histories. Most, but not all included social/smoking histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, and complete physical exams with vital signs. Moving forward, the Medical Department should focus on ensuring medical assessments include pre-natal histories, family history, childhood illnesses, pertinent laboratory information, updated active problem lists, and plans of care for each active medical problem, when appropriate.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #186 – diabetes, and other: lupus; Individual #166 – other: hyponatremia, and osteoporosis; Individual #277 – gastrointestinal (GI) problems, and osteoporosis; Individual #355 – osteoporosis, and cardiac disease; Individual #88 – osteoporosis, and infections; Individual #194 – other: kidney disease, and osteoporosis; Individual #287 – other: hypothyroidism, and osteoporosis; Individual #305 – osteoporosis, and diabetes; and Individual #119 – respiratory compromise, and other: hypertension].

As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. The PCP should review the individual's health status at least every six months. Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs should define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. Some of these standards of practice are defined in Appendix entitled "Disease-Specific Standards of Care." Plans of care in AMAs should define the frequency of review by PCPs as well as consultants, and these reviews should be included as action steps in IHCPs. If the individual has a diagnosis or at-risk condition that requires periodic review, and the ISP does not define the frequency of review, this indicator will be scored as "0."

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	186	166	277	355	88	194	287	305	119
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #186 – diabetes, and other: lupus; Individual #166 – other: hyponatremia, and osteoporosis; Individual #277 – gastrointestinal (GI) problems, and osteoporosis; Individual #355 – osteoporosis, and cardiac disease; Individual #88 – osteoporosis, and infections; Individual #194 – other: kidney disease, and osteoporosis; Individual #287 – other: hypothyroidism, and osteoporosis; Individual #305 – osteoporosis, and diabetes; and Individual #119 – respiratory compromise, and other: hypertension]. The IHCP that met criterion for this indicator was for Individual #305 – osteoporosis. b. None of the IHCPs reviewed defined the frequency of medical review based on current standards of practice.										

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Since the last review, improvement was noted with regard to the timely completion of annual dental exams. Although it appeared the dental summaries were timely, some were not signed and it was unclear who completed them (e.g., the dentist or the Registered Dental Hygienist). The Center should continue to focus on improving the quality of dental exams and summaries. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual	N/A									

	receives a dental examination and summary within 30 days.										
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. Since the last review, it appeared that significant improvement occurred with regard to the timeliness of dental exams.

b. It was positive that all of the dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- An odontogram:
- Periodontal risk; and
- Specific treatment provided.

Most, but not all included:

- An oral cancer screening;
- Sedation use;
- A description of periodontal condition; and
- Caries risk.

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

- Information regarding last x-ray(s) and type of x-ray, including the date;
- Periodontal charting;
- A summary of the number of teeth present/missing;
- The recall frequency; and
- A treatment plan.

c. Of concern, some of the dental summaries were not signed (i.e., Individual #277, Individual #355, Individual #194, and #287) and it was unclear who completed them (e.g., the dentist or the Registered Dental Hygienist). In other instances, data was not consistent between the summaries and other documentation (i.e., Individual #355, Individual #194, and #287). These discrepancies called into question the overall quality of the dental summaries. On a positive note, the few remaining dental summaries included the following:

- Recommendations related to the need for desensitization or another plan;
- 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;
- Effectiveness of pre-treatment sedation;

- Provision of written oral hygiene instructions;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations;
- A description of the treatment provided; and
- Treatment plan, including the recall frequency.

None of the summaries included the following, as applicable:

- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health.

Nursing

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

Summary: Partly due to issues with IRIS, full annual and quarterly reviews, and physical assessments were not documented for the individuals reviewed. 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.

#	Indicator	Overall Score	Individuals: 186	166	277	355	88	194	287	305	119
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	29% 4/14	1/2	1/1	1/2	0/2	N/A	0/1	1/2	0/2	0/2

Comments: a. Complete physical assessments were not done for the individuals reviewed. Some of the components that were missing were weight records, Braden scores, integumentary/skin assessments, and genitourinary systems assessments. Some of this was due to issues with IRIS. The nurses on the Monitoring Team have discussed these concerns with the State Office Nursing Discipline Lead. In addition, some individuals had missing quarterly reviews, vital signs, and/or physical assessments. For some individuals, abnormal findings were documented without follow-up or explanation. In other instances, words were cut off from the print-outs the Center provided.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #186 – circulatory, and constipation/bowel obstruction; Individual #166 – respiratory compromise, and weight; Individual #277 – GI problems, and skin integrity; Individual #355 – constipation/bowel obstruction, and falls; Individual #88 – GI problems, and skin integrity; Individual #194 – dental, and GI problems; Individual #287 – fractures, and infections; Individual #305 – constipation/bowel obstruction, and seizures; and Individual #119 – respiratory compromise, and weight).

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

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

- On 3/30/17, Individual #186 had a fecal impaction for which she was hospitalized and required cleanout with medication and manual disimpaction. Despite a medium risk rating for constipation/bowel obstruction, based on a review of IPNs from 3/1/17 to 3/31/17, no evidence was found that nursing staff were assessing and monitoring her bowel elimination patterns or lack thereof.
- On 11/12/16 at 9:30 p.m., an initial nursing IPN indicated that at 3:00 p.m., staff reported that Individual #166 ate a cigarette butt. The next nursing entry was on 11/13/16 at 2:12 p.m. Similarly, for a pica incident on 2/22/17 at 11:00 a.m., the next nursing entry was on 2/23/17 at 2:16 p.m. For these two events, nursing staff did not follow nursing protocols for pica, including assessing the individual's bowel sounds, monitoring for constipation, and checking stools for blood or foreign bodies.
- On 10/12/16 at 10:16 a.m., a direct support professional reported that Individual #355 did not want to walk, and refused to bear weight on his right leg. When nursing staff attempted to administer his medications, he was refusing to walk, dropping to the ground, and biting his right hand. No additional nursing assessment (i.e., head to toe) or vital signs were documented in IPNs or IView. The next nursing entry was dated 10/31/16.
- Between January and March 2017, Individual #119 had numerous episodes of emesis documented. Based on a random review of nursing IPNs for these instances, nursing staff did not follow nursing protocols in assessing Individual #119. For example, nursing staff did not assess intake and output, and/or document what position she was in, when the emesis "containing food particles was present on the individual's chest."

- Individual #119 also had an unplanned weight gain of 11.9 pounds. However, nursing IPNs did not include an assessment related to intake and output, or whether or not she had a decline in her activities of daily living or mobility. No evidence was found that nursing staff reweighed her.

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 the Center's scores have consistently been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 186	166	277	355	88	194	287	305	119
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. through f. It is essential that the Center focus on improving individuals' IHCPs.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.

Summary: It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. Since the last review, some improvement was seen with

Individuals:

regard to timely referral of individuals to the PNMT, and timely completion of the PNMT initial review. The Center should focus on continuing its progress in these areas, as well as improving referral of all individuals that meet criteria for PNMT review, completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT comprehensive assessments.											
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	63% 5/8	0/1	N/A	0/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	75% 6/8	0/1		0/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	40% 2/5	0/1		0/1	1/1	N/A	N/A	0/1	1/1	N/R
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	57% 4/7	0/1		0/1	1/1	1/1	1/1	0/1	1/1	N/R
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 3/3	N/A		1/1	N/A	1/1	N/A	1/1	N/A	N/R
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	29% 2/7	0/1		0/1	0/1	1/1	1/1	0/1	0/1	N/R
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	N/A	N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5	0/1		0/1	0/1	N/A	N/A	0/1	0/1	N/R
Comments: a. through d., and f. and g. For the eight individuals that should have been referred to and/or reviewed by the PNMT: • Despite reports of 24 falls from October 2016 through March 2017, Individual #186's IDT did not revise her IRRF or IHCP.											

QIDP notes quoted a Falls Risk Assessment, dated 2/3/17, that reported she had experienced one to two falls in the last three months, but other documentation submitted indicated that she had at least 16 falls during that time. In addition, she had a choking event for which her IDT did not refer her to the PNMT. Although the PNMT discussed Individual #186, it was limited discussion, and could not be considered a review.

- On 12/6/16, Individual #277 was diagnosed with aspiration pneumonia. On 1/26/17, he was diagnosed with pneumonia. On 1/31/17, he had possible aspiration pneumonia. On 2/9/17, he was diagnosed with aspiration pneumonia. On 7/24/13 and 1/15/14, the PNMT assessed him. However, recently, there was no evidence of referral or formal review other than PNMT RN post-hospitalization reviews, and PNMT review of these reviews.
- Notes indicated that Individual #355 had a 10 percent weight loss from January 2016 (105.2) to April 2016 (94.8), and additional weight loss in May 2016 (93.4). In June 2016, his lowest weight was recorded as 86.2 pounds. It was not until 6/16/16 that the PNMT discovered a 7.2 percent weight loss in one month and self-referred him. Based on the documentation provided, it did not appear that a physician/provider was involved in the PNMT assessment of Individual #355.
- On 1/1/17, Individual #88 sustained a hip fracture, when a peer pushed him. From 1/1/17 to 1/16/17, he was hospitalized, and on 1/20/17, he was referred to the PNMT. The PNMT provided a reasonable rationale for not needing to conduct a full assessment: "Isolated incident due to aggression from a peer. His recovery will be facilitated by PT, which can be conducted by the IDT. This trauma did not impact multiple systems. The need for intubation due to respiratory failure was the result of noncompliance with oral instructions while [Individual #88] was hospitalized immediately after surgery. [Individual #88] has had no further incidents of aspiration/respiratory compromise." However, the review the PNMT conducted was not sufficient to address his needs. For example, the review offered very limited discussion of the incident, and course of intervention post-surgery, such as additional PNM supports, physical therapy, progress, current status, what his baseline function was and expectations for return to baseline. It did not reflect review of his supports and whether they currently met his needs. It did not make recommendations, or clearly state that recommendations were not indicated.
- In April 2017, the PNMT conducted a review of Individual #194's weight loss. The weight loss, though not planned, brought her back within her estimated desired weight range (EDWR) and followed several GI-related hospitalizations. The review was insufficient to meet her needs in that it was lacking details related to weight range, history, and intake. The review stated the PNMT did not have enough information in a couple of areas. The PNMT should have obtained this information as part of their review.
- On 2/7/17, the PNMT RN attended an ISPA meeting that addressed Individual #287's mother's request for percutaneous endoscopic gastrostomy (PEG) tube placement, although the IDT believed it was not medically necessary. The PNMT RN stated that the PNMT would conduct an assessment for new tube placement. On 2/9/17, according to the PNMT RN's IPN, the IDT held another ISPA meeting during which they asked the PCP about the individual's return to oral intake, and the PCP said this would be addressed later. According to another PNMT RN IPN, on 2/16/17, the PCP was to write an order for nothing-by-mouth status. Individual #287 was re-hospitalized for cardiac complications. He refused an oral intake trial, and his IDT changed his aspiration as well as his GI risk rating to high. He moved to a different home on campus for medical monitoring. He went to the ED due to fecal impaction, respiratory failure with hypoxia, heart murmur with severe mitral valve regurgitation. The PEG tube was replaced with a gastrostomy tube. On 2/23/17, the PNMT reviewed the RN post-hospitalization assessment. The PNMT decided that although he had received a new PEG tube that "was not medically necessary," but rather the guardian's request due to fears of weight loss, the IDT would address his return to oral intake and other issues. They did not complete a full assessment, even though they stated he was at greater risk for aspiration. He was

discontinued from PNMT review. On 3/5/17, he died with cause of death stated as myocardial infarction due to Influenza B.

- The PNMT completed a comprehensive assessment to address Individual #305's weight loss. He was referred timely, and the assessment was timely, which was good to see. However, Behavioral Health Services was not involved in his assessment.
- At the time the document request was due, Individual #199's PNMT assessment was still in process. While on site, the Monitoring Team member provided verbal feedback to the PNMT, but the assessment was not used for purposes of this review.

e. It was positive that as needed, RN Post Hospitalization Reviews were completed for the applicable individuals reviewed, and the PNMT discussed the results.

h. As noted above, three individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #186's, Individual #277, and Individual #287). The following summarizes some of the concerns noted with the two assessments that the PNMT completed:

- The PNMT identified the following as "root causes" of Individual #355's unplanned weight loss: chronic normocytic, normochromic anemia, hyperparathyroidism (i.e., identified that these might have contributed to sluggishness and loss of appetite, but no underlying causes of anemia identified; and indicated that the last endocrine consult was in 2014, but nothing at the current time), and reduced meal intake. These are not all true root causes. For example, the PNMT had not determined the cause of his reduced meal intake. Other contributing factors included lack of compliance with snack provision and bringing him in to dining room for all meals. The only goal listed was: "maintain EDWR 88-108# x 6 months" (Target date 1/16/17). This goal did not address the underlying cause(s) or etiology(ies) of the weight loss.
- For Individual #305, the recommendations did not capture the etiology or actions to be taken. In addition, the recommended goals did not address the etiologies, which were described as decreased intake, dental issues (abscess), lethargy related to seizure and psychiatric medications, uncooperative behavior and aggression, and diagnosis of constipation and fecal impaction. Not all of these are true root causes. For example, the PNMT did not discuss the cause of the decreased intake, or the causes of the aggression and uncooperative behavior. There was no evidence that they collaborated with Behavioral Health Services to address these issues.

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	186	166	277	355	88	194	287	305	119
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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	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.	17% 3/18	0/2	0/2	0/2	0/2	0/2	0/2	2/2	0/2	1/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: choking, and falls for Individual #186; choking, and weight for Individual #166; falls, and aspiration for Individual #277; falls, and weight for Individual #355; choking, and fractures for Individual #88; choking, and falls for Individual #194; fractures, and aspiration for Individual #287; falls, and weight for Individual #305; and circulatory, and respiratory compromise for Individual #119.

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

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMP for Individual #194 included all of the necessary components to meet the individual's needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example, Individual #287's medication administration section of his PNMP had not been updated to include his nothing-by-mouth status. Five individuals' PNMPs had incomplete risk information. For each of the following, two or more PNMPs included incomplete or inaccurate information: transfers, mobility, bathing, toileting, handling instructions, mealtime instructions, medication instructions, and oral hygiene instructions. On a positive note, assistive/adaptive equipment and positioning instructions were complete for all nine individuals, as were the communication instructions.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring. The exceptions were for fractures, and aspiration for Individual #287; and respiratory compromise for Individual #119.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119

a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/2	N/A	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	N/A			N/A				N/A		
Comments: a. and b. For Individual #277, the IDT did not document discussion of continued medical necessity. Individual #287's parent elected tube placement, because she was worried about potential weight loss. The IDT identified that he had maintained his weight and that the data indicated that there was no medical necessity for tube placement. However, on 2/7/17, the tube was placed. Ultimately, Individual #287 had cardiac complications and was re-hospitalized, and on 3/5/17, died.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	71% 5/7	0/1	1/1	0/1	1/1	N/R	1/1	N/R	1/1	1/1

b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	79% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	N/A									
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1

Comments: Individual #355 was part of the outcome group and did not require formal OT/PT supports beyond a PNMP, so a limited review was conducted for him.

a. and b. The following provide examples of concerns noted:

- For Individual #186, in accordance with the audit tool, the Monitoring Team reviewed the documents submitted in response to its request for OT/PT assessments, and updates, as well as any OT/PT consultations. Since her ISP meeting, the OT/PT did not complete an update or reassessment in response to an increase in the number of falls she experienced, and the Center's response to the request for consults indicated "Not applicable." In July 2016, the most recent update identified changes in function, but the OT/PT offered no recommendations to address these changes. The assessment stated she was still falling, and reported 13 falls in the previous year, but recommended no increase in monitoring, no increase in supports, interventions, etc.
- For Individual #277, the OT/PT completed the annual update on 12/29/16, for an ISP meeting, dated12/27/16, but according to the State's comments on the draft report, the meeting was held on 1/11/17. The Monitoring Team had no way to confirm this assertion, but in any event, the assessment was not completed timely. He had at least five falls since the OT/PT annual evaluation and hospitalizations for aspiration pneumonia/pneumonia (three in January 2017, and two in February 2017, in addition to previous events in August and December 2016) with no evidence of OT/PT review related to these risk areas beyond routine effectiveness monitoring. These events should have triggered a reassessment to at least confirm that there was

no change in physical status, or discover that he would benefit from additional OT/PT supports.

- The Monitoring Team could not determine the timeliness of the annual update for Individual #88, because the Center did not submit one. However, the Monitoring Team reviewed the change-of-status update.
- The Monitoring Team could not determine the timeliness of the annual update for Individual #287, because he died prior to his ISP meeting.
- The ISPs for Individual #305 and Individual #355 that the Center submitted to the Monitoring Team were not dated correctly (i.e., it was impossible to determine the actual date the meeting was held from the documents the Center submitted). After obtaining an explanation from State Office as well as description of the State's actions to correct this moving forward, the Monitoring Team modified the scores for these two individuals. However, in the further, it is essential that when providing comments to draft reports, Center and State staff review the documents the Center submitted and tailor its comments accordingly.

e. For Individual #88, it was positive that a thorough OT/PT update was completed in response to his change of status, and that the OT/PT developed an ambulation program to address his strong desire to walk.

As noted above, Individual #186 should have had a reassessment, but did not. The following summarizes additional examples of concerns noted with regard to the required components of the remaining OT/PT updates:

- 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: Most assessments met this criterion. However, for two individuals, the assessments did not discuss diagnoses and their impact on functional status;
- The individual's preferences and strengths are used in the development of OT/PT supports and services: for a couple of individuals, assessors did a good job of incorporating the individuals' preferences, but for most individuals reviewed, individuals' preferences were not applied to improving their OT/PT-related needs;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: Most assessments met this criterion, which was good to see. For one individual, the update did not identify whether or not the individual experienced potential side effects, and/or provide an analysis of the possible impact on OT/PT services;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): For one individual, the update did not fully discuss her seating system, although it identified that the wheelchair frame was old and in need of replacement;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Most of the updates reviewed had concerns noted with this sub-indicator. At times, the updates provided no review of monitoring findings or other data necessary to determine the effectiveness of supports. When progress was not made on goals/objectives, analysis was not completed to identify the cause for the lack of progress;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: Because individuals often did not have goals/objectives that were clinically relevant and measurable, the updates often did not include evidence regarding progress, maintenance, or regression. Often clinical criteria that assessors identified were not measurable. For at least one individual, data included in the update (e.g., related to falls) was not consistent with data found in other documents; 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: Some updates did not address identified needs through recommendations, and/or provide clinical justification for not providing OT/PT supports and/or services.

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

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; and
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

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

Summary: It was good to see some improvement from the last review with regard to IDTs reviewing and making changes to individuals' ISPs/IHCPs through ISPAs, when changes occurred with regard to individuals' OT/PT services and supports. However, the Center needs to improve its performance with regard to all of these indicators. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 186	166	277	355	88	194	287	305	119
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	22% 2/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	33% 3/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	20% 1/5	0/1	N/A	0/1	N/A	N/A	N/A	0/1	0/1	1/1
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.	67% 2/3	0/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1

Comments: a. It was concerning that the ISPs of a number of individuals reviewed provided incomplete descriptions of their functional status from an OT/PT perspective. For example, Individual #186 and Individual #277's descriptions did not address gait issues and/or issues related to falls.

c. and d. On a positive note:

- In February 2017, the IDT for Individual #88 held an ISPA meeting related to an update, dated 2/13/17, that addressed a change in status, and the IDT developed goals and objectives.
- Individual #119's IDT included a walking program with the PT in her ISP, and then held an ISPA to modify it to a standing program.

Examples of concerns noted included:

- Individual #186's ISP did not include strategies/interventions in her ISP/IHCP to address the underlying cause of her ongoing falls. In addition, although Individual #186's IDT held an ISPA meeting to discuss the introduction of a recumbent bicycle, the IDT did not modify the ISP/IHCP to include a goal/objective and/or measurable strategy.
- Individual #305's IDT discontinued his previous SAP to propel himself from the living area to the dining room when it was time to eat, because he had not made progress. It was unclear why they did not modify the SAP, as opposed to discontinuing it. There also was no evidence that the IDT considered interests and preferences to improve his performance. His assessment offered no recommendations for a SAP or other interventions for the current ISP year, even though he had unmet needs.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: The Center should focus on improving the quality of communication updates. The remaining indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	Individual receives timely communication screening and/or assessment:	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.										
	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.										
	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.										
b.	Individual receives assessment in accordance with their individualized needs related to communication.										

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

Comments: c. Individual #186's screening did not identify diagnoses, report vision and hearing status, or discuss medications that might impact communication, and provided a limited description of the individuals' receptive and expressive communication skills.

e. The following provide examples of concerns noted with regard to the required components of the communication updates for seven individuals:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: Most of the updates met this criterion. However, for the two that did not, the issue was that the assessors did not describe the relevant impact on communication of diagnoses and health status;
- The individual's preferences and strengths are used in the development of communication supports and services: Most of the updates met this criterion. However, for the two that did not, the issue was that the assessors did not apply the list of preferences and strengths when developing communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: For the four updates that did not meet this criterion, relevance to communication supports and services of side effects to medication was not stated, or recommendations for changes in communication supports were not offered when medications were impacting an individual's communication;
- The effectiveness of current supports, including monitoring findings: For some updates, monitoring findings were not included, or were not sufficient to determine the effectiveness of supports;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: None of the

assessments met this criterion. Often, the assessors evaluated existing supports, but provided no evidence of actual assessment of AAC or the need for further supports; 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: None of the assessments met this criterion. A number of the updates did not contain sufficient assessment information to determine whether or not recommendations were needed. For two individuals, the recommendations did not show needed collaboration with Behavioral Health Services staff to address functions of behavior that were related to communication.

On a positive note, all of the updates sufficiently addressed the following:

- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills.

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: Although the ISPs of individuals reviewed generally contained strategies, interventions, and programs recommended in communication 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.

#	Indicator	Overall Score	Individuals: 186	166	277	355	88	194	287	305	119
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.	50% 4/8	1/1	0/1	1/1	1/1	0/1	N/R	0/1	1/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	14% 1/7	N/A	1/1	0/1	0/1	0/1		0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	88% 7/8	0/1	1/1	1/1	1/1	1/1		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.	N/A									

Comments: a. For four individuals, their ISPs did not provide complete functional descriptions of their communication skills, including,

for some, how they used AAC devices or what signs they knew.

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: San Antonio SSLC had skill acquisition plans for every individual and they were measurable. This has been the case for some time and, therefore, these two indicators (1, 2) will be moved to the category of requiring less oversight. The other three indicators showed steady progress and improvement compared with the previous two reviews. They will remain in active monitoring.

The facility recently implemented the new SAP pilot project to improve the quality of SAP development and implementation (mentioned in the last report, too). None of the SAPs selected for review by the Monitoring Team were in the new SAP format. The Monitoring Team did, however, review some of the new format SAPs for other individuals with the director of active treatment, training, and development, and the state office discipline coordinator for skill acquisition programming. The new format appears to address the concerns raised in this report regarding the quality of content and the components and quality of review (i.e., data based decisions to continue, discontinue, or modify SAPs) of the SAPs. The Monitoring Team looks forward to seeing the results of this new SAP format at the next review.

#	Indicator	Overall Score	Individuals: 294	304	291	118	179	166	320	186	342
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 25/25	3/3	2/2	2/2	3/3	3/3	3/3	3/3	3/3	3/3
3	The individual's SAPs were based on assessment results.	100% 25/25	3/3	2/2	2/2	3/3	3/3	3/3	3/3	3/3	3/3
4	SAPs are practical, functional, and meaningful.	68% 17/25	3/3	2/2	1/2	3/3	1/3	1/3	2/3	2/3	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	72% 18/25	0/3	2/2	2/2	3/3	3/3	3/3	2/3	3/3	0/3

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 #291 and Individual #304, for a total of 25 SAPs for this review. Teams might consider SAPs for the many skills that these two individuals could learn to improve their independence and obtaining of preferences.

2-3. All of SAPs were measurable and based on assessment results.

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 #291's vocational SAP of filling a bag of candy).

5. It was encouraging to see a substantial increase in SAPs with interobserver agreement (IOA). The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data in real life) for all SAPs.

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: With some attention, all of these indicators could be brought to 100% performance. With sustained high performance, indicators 10 and 12 might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	291	118	179	166	320	186	342
10	The individual has a current FSA, PSI, and vocational assessment.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	67% 6/9	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:
10. Eight individuals had current FSAs, PSIs, and vocational assessments (if appropriate). The exception was Individual #291, who did not have a PSI.

11. Individual #166 and Individual #291's PSIs, and Individual #342's FSA were not available to the IDT at least 10 days prior to their ISP.

12. Eighty-nine percent of the individual's FSAs and vocational assessments included recommendations for SAPs. The exception was Individual #179'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. At the last review, 10 of these indicators were moved to the category of requiring less oversight. For this review, 10 other indicators were added to this category, in restraints and dental, including one full outcome: dental outcome 7.

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

Regarding the implementation of more than three crisis intervention restraints in any rolling 30-day period, there were improvements showing that the IDT took actions to better understand and implement plans to reduce restraint for these individuals. To be more specific, for the two individuals, all indicators were met for both individuals, except for indicator 20.

Even given the psychiatry staffing challenges over the past nine months, the facility prioritized the conducting of quarterly psychiatry clinic reviews and the results were evident in the 100% score for this indicator.

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.

Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. Although some improvement was noted since the last review, 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. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed significant improvement.

Acute Illnesses/Occurrences

In psychiatry, without measurable goals, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all but one of the individuals.

Implementation of Plans

In behavioral health, given the absence of good, reliable data, progress could not be determined for all of the individuals. This was due to a change in data collection systems. The department had a plan to correct this in the future. Though work was needed on the data collection system, the summary 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.

Numerous problems were identified with regard to the provision of medical care. These are not new findings, and they need to be addressed, because they have the potential to place individuals at risk. Some of the problems noted included:

- Overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Center and/or in other settings did not meet generally accepted standards of care, and for some individuals reviewed, significant concerns were noted. For the past three reviews, the Center has shown poor compliance with these essential requirements.
- Significant work was needed to ensure that for individuals' chronic or at-risk conditions, medical assessments, tests, and evaluations consistent with current standards of care were completed, and PCPs identified and implemented the necessary treatment(s), interventions, and strategies, as appropriate.
- Of significant concern, only one of the nine individuals reviewed received the preventative care they needed.
- 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/ISPs.
- The Center also should focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

For one individual the Monitoring Team reviewed, medical staff had prescribed, and nursing staff administered Versed after he had multiple seizures. According to a quarterly nursing review, dated 1/6/17, Versed was administered seven times in the previous quarter. Per the Versed package insert, "regardless of route, continuous cardiac and respiratory monitoring is required" with the use of this medication. Based on documentation provided, it did not appear that this occurred, or that the Center has the resources to provide such monitoring. This issue has been raised with State Office. It also was unclear whether or not the individual's medication refusals impacted his need for Versed, and if so, whether or not the IDT was addressing his refusals.

Overall, the Center needs to make improvements with regard to the provision of dental care and treatment. On a positive note, though, for the individual reviewed for which two dental emergencies occurred, the Dental Department provided emergency dental care in a timely manner. Over three reviews, the Center had done consistently well with the three indicators related to emergency dental care, so this entire outcome will move to the category requiring less oversight.

Since the last review, it was good to see improvement with regard to the timely completion of Quarterly Drug Regimen Reviews (QDRRs). The Center should continue to focus on the quality of the QDRRs.

Proper fit of wheelchairs was sometimes still an issue.

Based on observations, there were still numerous instances (47% of 53 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.												
Summary: Performance continued to improve for these important protections for individuals with frequent restraint. For instance, seven of the indicators scored at 100% for this and the previous two reviews (with one exception in November 2015) and, therefore, will be moved to the category of requiring less oversight (indicators 18, 19, 23, 24, 27, 28, 29). Indicator 20 was the only indicator in this outcome that did not meet criteria. It and the other four indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	320	186								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 2/2	1/1	1/1								
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 2/2	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% 0/2	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.	100% 2/2	1/1	1/1							
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?	100% 2/2	1/1	1/1							
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, 2. and if any were hypothesized to be relevant, a plan to address them.	100% 2/2	1/1	1/1							
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2	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% 2/2	1/1	1/1							
26	The PBSP was complete.	N/A	N/A	N/A							
27	The crisis intervention plan was complete.	100% 2/2	1/1	1/1							
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 2/2	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% 2/2	1/1	1/1							

Comments:
18-29. This outcome and its indicators applied to Individual #320 and Individual #186.

18. Individual #320 had his fourth restraint in 30 days on 10/24/16, and his IDT met on 10/28/16 to address these restraints. Individual #186 had her fourth restraint in 30 days on 3/7/17, and her IDT met on 3/9/17 to address these restraints.

20. Although Individual #320 and Individual #186's ISPAs following more than three restraints in 30 days reflected a discussion of adaptive skills, and biological, medical, and psychosocial issues, it was not clear which, if any, of these factors were suggested to contribute to his restraints.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: Indicators 2 and 3 will remain in active monitoring for the next review.			Individuals:									
#	Indicator	Overall Score										
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A										
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A										
Comments:												

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 all but one of the individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
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.	86% 6/7	N/A	1/1	N/A	1/1	0/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 6/6	N/A	1/1	N/A	1/1	N/A	1/1	1/1	1/1	1/1
Comments: 8-9. Without measurable goals and objectives integrated into the IHCP, progress could not be determined. Thus, the first two indicators are scored at 0%. 10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases											

in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented. There was one exception, Individual #179. The psychiatric clinical documentation for this individual stated that the current management would continue although the current treatment plan was not effective. That is, it read "baseline maladaptive behaviors persist due to lack of consequences…continue current non effective treatment plan."

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

Summary: With the new psychiatry staffing, it is likely that the coordination between psychiatry and behavioral health will improve. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	291	118	179	166	320	186	342
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	13% 1/8	N/A	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
23. The psychiatric documentation did not routinely reference specific behaviors that were being tracked by behavioral health. Although the functional assessment regularly included information regarding the individual's psychiatric diagnosis, there was no discussion regarding the effects of said diagnosis on the target behaviors.

The one exception was Individual #179. There was documentation of her psychiatric diagnoses in behavioral health information and there was documentation of the challenging behaviors monitored by behavioral health in the psychiatric clinical documents.

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

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

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	291	118	179	166	320	186	342
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
26	Frequency was at least annual.	0%	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

		0/1									
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

Comments:
25-27. These indicators applied to one individual, Individual #320. This individual was admitted to the facility in 2015. There was documentation of two clinical encounters with neurology in 2016. Per neurology, this individual was prescribed Depakote for a dual purpose due to a history of seizure activity. Per psychiatric clinical documentation, this individual did not have a history of a seizure disorder.

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

Summary: San Antonio SSLC prioritized the conducting of quarterly psychiatry clinic reviews and the results are evident in the 100% score for indicator 33. Attention to the content of the reviews is needed. All three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	291	118	179	166	320	186	342
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
33. Quarterly evaluations were completed in a timely manner. This was an improvement since the last review and was good to see, especially given the challenges in maintaining psychiatric provider staffing over the previous nine-month period.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing seven to eight components. All reviews included information regarding the individual's attendance at clinic. There was a mental status examination and an attestation by the psychiatrist that the individual had been seen in conjunction with the clinical encounter.

35. Psychiatry clinic was not conducted during the monitoring visit due primarily to the recent hiring of the new psychiatric provider. Clinics were scheduled to begin the week after the onsite review.

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

Summary: This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	291	118	179	166	320	186	342

36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 36. Assessments were occurring in a timely manner. The prescriber review, however, did not occur within the required time frame.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: Standard return following medication changes should occur as noted below. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
37	Emergency/urgent and follow-up/interim clinics were available if needed.	33% 2/6	N/A	0/1	0/1	N/A	N/A	1/1	0/1	1/1	0/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A
Comments: 37-38. Emergency/interim clinics were available and there was documentation of emergency/interim clinics occurring for Individual #166 and Individual #186. There were four individuals who had adjustments to their medication regimens, but were not requested to return to clinic until the next scheduled quarterly: Individual #320, Individual #342, Individual #304, and Individual #291. If an individual's medication regimen is adjusted, he or she should return to clinic within two weeks for a follow-up review. 39. When clinics occurred, documentation was appropriate.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These important indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	67% 6/9	1/1	1/1	1/1	0/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	followed policy.										

Comments:
40. There were three individuals, Individual #166, Individual #118, and Individual #186, who had very complex medication regimens that included either multiple medications or high doses of medications. Although there was no indication that the goal was sedation, these high dosages should be reviewed. Also, see indicator 44 below.

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.

Summary: Polypharmacy justification needed to occur. Also, polypharmacy committee needs to occur in a way that meets the professional standard of being a facility-level review. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	0% 0/7	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
45	There is a tapering plan, or rationale for why not.	86% 6/7	N/A	1/1	1/1	1/1	1/1	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.	100% 7/7	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A

Comments:
44. These indicators applied to seven individuals. Polypharmacy justification was not documented for any of the individuals who met polypharmacy criteria. Individual #186 and Individual #166 had very complicated psychotropic medication regimens, both of which met the criteria for polypharmacy. During the onsite week, the Monitoring Team talked with the facility's administration about the need for these two cases to get additional attention from psychiatry and from their IDTs.

45. There was documentation of a rationale regarding medication tapers for six individuals.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for seven individuals selected by the Monitoring Team who met criteria for polypharmacy.

However, the polypharmacy committee at San Antonio SSLC was coordinated and chaired by psychiatry clinic staff. This was not appropriate. Polypharmacy committee should be a facility-level review of medication regimens that meet the 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: Given the absence of good, reliable data, progress could not be determined for all of the individuals. The Monitoring Team scored indicators 7, 8, and 9 based upon the facility's report of progress/lack of progress as well as the ongoing exhibition of problem target behaviors. The indicators in this outcome will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
6	The individual is making expected progress	0% 0/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	25% 1/4	N/A	N/A	N/A	N/A	0/1	N/A	0/1	0/1	1/1
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 3/3	N/A	1/1	N/A	N/A	1/1	N/A	N/A	1/1	N/A
9	Activity and/or revisions to treatment were implemented.	100% 3/3	N/A	1/1	N/A	N/A	1/1	N/A	N/A	1/1	N/A

Comments:

6. Individual #304, Individual #179, and Individual #186's PBSP data indicated that they were not progressing. Individual #291, Individual #118, Individual #166, Individual #320, and Individual #342's facility data reported that they were progressing or maintaining low rates of target behaviors, however, the data were not demonstrated to be reliable (see indicator 5), so they were not scored as progressing.

7. Individual #342 achieved his physical aggression and self-injurious behavior (SIB) objectives in February 2017, and new objectives were developed in March 2017. On the other hand, Individual #186 achieved her disruptive behavior, false allegations, SIB, and unauthorized departures (UD) objectives in December 2016, but they were not revised in March 2017. Similarly, Individual #320's UD and physical aggression objectives, and Individual #179's false allegations, and refusals objectives were achieved in February 2017, but were not revised in March 2017.

8-9. Individual #304, Individual #179, and Individual #186's progress notes included actions to address their lack of behavioral progress, and there was evidence that those actions were implemented.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary:			Individuals:								
#	Indicator	Overall	294	304	291	118	179	166	320	186	342

		Score									
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.	75% 6/8	N/A	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										
Comments: 16. 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 its implementation. Individual #166 and Individual #186 were the exceptions.											

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: Improvements in graphing resulted in performance improving to 100% compared with about 50% during the past two reviews. With sustained high performance, this indicator might be move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.										
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.										
Comments: 20. All 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.											

Outcome 8 – Data are collected correctly and reliably.											
Summary: After previous high performance, recent changes in the data collection system and electronic record resulted in criteria not being met for four of these indicators. The behavioral health services department had a plan to make corrections going forward. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	13% 1/8	N/A	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

26. The data collection system for all individual's target behaviors has recently been changed to a system where staff are only required to record data once a shift. This system does not encourage regular data collection, and would not likely provide an adequate measurement of behaviors that occur at high rates.

27. The data collection system for all individuals, other than Individual #304's, replacement behaviors had recently been changed to a system where staff were only required to record data once a shift. This system did not encourage regular data collection, and would not likely provide an adequate measurement of behaviors that occurred at high rates. Individual #304's replacement behaviors were recorded following each occurrence, by her behavior analyst.

28. There were established measures of IOA, data collection timeliness, and treatment integrity. Data collection timeliness, however, was not adequately measured in the current data collection system

29. There were established frequency and minimal levels of IOA, data collection timeliness, and treatment integrity for all individual's PBSP data.

30. All of the individuals had IOA, data collection timeliness, and treatment integrity that exceeded minimum goal frequencies and levels, however, because the data timeliness measure was judged to be inadequate (see indicator 28), this indicator was scored 0.

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	186	166	277	355	88	194	287	305	119
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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #186 – diabetes, and other: lupus; Individual #166 – other: hyponatremia, and constipation/bowel obstruction; Individual #277 – GI problems, and osteoporosis; Individual #355 – seizures, and cardiac disease; Individual #88 – osteoporosis, and infections; Individual #194 – other: kidney disease, and osteoporosis; Individual #287 – infections, and other: hypothyroidism; Individual #305 – osteoporosis, and diabetes; and Individual #119 – respiratory compromise, and other: hypertension).

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: Of significant concern, one of the nine individuals reviewed received the preventative care they needed. The Monitoring Team will continue to review these indicators. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of	Individuals:

benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.											
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	Individual receives timely preventative care:										
	i. Immunizations	56% 5/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
	ii. Colorectal cancer screening	57% 4/7	N/A	N/A	1/1	0/1	0/1	1/1	1/1	0/1	1/1
	iii. Breast cancer screening	0% 0/3	0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1
	iv. Vision screen	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
	v. Hearing screen	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	56% 5/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1
	vii. Cervical cancer screening	67% 2/3	1/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	1/1
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. The following problems were noted:

- For Individual #186, the mammogram report available was dated in 2014, although the quarterly medical summary stated one was done on 11/17/16. On 2/16/15, a vision exam recommended follow-up in one year, but no follow-up exam was completed. Similarly, a hearing screening was completed in 2014. She was scheduled for evaluation on 4/27/16, but did not attend. The consultant indicated the appointment would be rescheduled, but documentation of the evaluation was not submitted.
- Individual #166 was at risk for osteoporosis, but no DEXA scan had been completed.
- No colonoscopy was documented for Individual #355. In addition, the immunization record did not document his hepatitis status.
- For Individual #88, on 1/17/13, the gastroenterologist noted that when the scope was inserted into the rectum, it was full of stool. Subsequent attempts to complete a colonoscopy failed, so it was documented that the gastroenterologist recommended that a fecal occult blood test (FOBT) be performed. There was no Preventive Care Flow Sheet (PCFS) submitted, so it could not be determined if the testing completed was high sensitivity FOBT.

- For Individual #194, no DEXA scan had been completed, but one had been ordered for March 2017. In addition, one page from AMA (which was not provided with the AMA) stated that her family declined cancer screenings, but this would be readdressed with them. This explanation was not sufficient.
- Individual #287's immunization record provided no documentation of varicella or Zoster. In addition, the Center did not submit the consultation report for the individual's eye examination.
- Individual #305's immunization record listed only three vaccines. Although the AMA listed others, these records need reconciliation. He was 63 years old, and had not had a colonoscopy. The record indicated that he had a FOBT, which was negative, but no description was provided of the type. Again, the Center did not submit a PCFS. He also had a diagnosis of osteoporosis, but no follow-up bone mineral density had been completed.
- Despite asthma with recurrent pneumonia, Individual #119 had not had a Prevnar 13 vaccine. She had a mammogram, dated 4/8/14, that was suboptimal. A 5/16/14 report noted that an ultrasound was performed that showed a probable benign lesion of the right breast. The recommendation was to repeat the screening in six months, but no evidence of follow-up was found. In 2012, Individual #119 had a DEXA scan that showed osteoporosis, but no follow-up was found.

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: The Monitoring Team will continue to review this indicator.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
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	0/1	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. For Individual #277, the AMA, dated 12/21/16, stated: "He is DNR due to chronic aspiration related to incompetent LES [lower esophageal sphincter]. He is not a candidate for a fundoplication due to his G-tube placement."											

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

Summary: Overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Center and/or in other settings did not meet generally accepted standards of care, and for some individuals reviewed, significant concerns were noted. For the past three reviews, the Center has shown poor compliance with these requirements. The Center needs to prioritize improvements in this area. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall	186	166	277	355	88	194	287	305	119

		Score									
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	0% 0/8	0/2	N/A	0/2	0/1	0/1	0/1	N/A	0/1	N/A
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	25% 2/8	0/2		1/2	0/1	0/1	0/1		1/1	
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	50% 5/10	N/A	1/1	1/2	1/1	0/1	N/A	0/1	1/2	1/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	43% 3/7		1/1	1/2	N/A	0/1		0/1	1/1	0/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	50% 5/10		1/1	1/2	1/1	0/1		1/1	1/2	0/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	50% 5/10		1/1	2/2	1/1	1/1		0/1	0/2	0/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	30% 3/10		0/1	0/2	1/1	0/1		0/1	2/2	0/2

Comments: a. and b. For six of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed eight acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #186 (perineal burning on 2/5/17, and contusion of right great toe on 3/27/17), Individual #277 (facial laceration on 12/23/16, and abscess on 1/15/17), Individual #355 (skin alteration on 10/7/16), Individual #88 (skin infection on 3/27/17), Individual #194 (tooth abscess on 3/13/17), and Individual #305 (lethargy on 2/27/17).

The acute illnesses/occurrences 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 were those for Individual #277 (facial laceration on 12/23/16), and Individual #305 (lethargy on 2/27/17).

The following provide examples of concerns noted:

- On 2/15/17, nursing staff documented that the MD was notified that Individual #186 complained of itching and burning in the vaginal area. Nursing staff noted that the nursing physical exam was unremarkable. The MD order was: "Give her Motrin and see what happens." Individual #186 refused Motrin stating that it burned, it did not hurt.
- On 3/27/17, nursing staff documented that Individual #186 had bruising to the right great toe. X-rays were ordered to rule out a fracture. There was no PCP documentation that the PCP conducted a physical exam. There was also no PCP documentation of the x-ray results, although a nursing note said the PCP reported the x-ray was negative.
- On 1/15/17, nursing staff documented that Individual #277 had a three centimeter (cm) by three cm pink circular lesion that was elevated. The on-call PCP was notified and Clindamycin was ordered. Nursing staff conducted follow-up for a diagnosis of left axillary abscess, but there was never a medical evaluation. Based on the records reviewed, the PCP ordered a seven-day course of antibiotic therapy without any documentation of a medical evaluation or a physician-determined diagnosis. The first PCP documentation was on 1/26/17, and it was related to pneumonia.
- On 10/7/16, the PCP noted in the IPNs that Individual #355 was being evaluated for a blister on the left thigh. The lesion was described as a thin walled blister with serosanguinous fluid with no surrounding erythema. The assessment/plan was "thin walled vesicular lesion-consider pemphigus, will monitor." There was no follow-up even though the diagnosis of pemphigus was being considered.
- On 3/27/17, nursing staff documented that Individual #88 had "redness/purple discoloration surrounding broken skin." The PCP was notified and ordered Augmentin 875 milligrams (mg) twice a day (BID) for seven days. There was no documentation of a medical evaluation. The PCP never documented the diagnosis for the use of this broad-spectrum antibiotic.
- On 3/10/17, nursing staff noted that the PCP would assess Individual #194 for an increased white blood count (WBC) count. The PCP did not document an assessment. On 3/13/17, nursing staff noted swelling to the individual's left cheek. Tylenol was given, and the nurse recommended sick-call follow-up in the morning or a dental appointment. On 3/14/17, the dentist noted a non-restorable tooth. The PCP was consulted and recommended a computerized tomography (CT) scan to rule-out non-dental etiologies. On 3/17/17, the dentist noted that the CT was done and the PCP would review it. Antibiotics were to continue. On 3/20/17, the dentist documented that the PCP "rules out sinusitis diagnosis" and the facial swelling was due to a tooth abscess. The PCP provided no documentation in the records of the elevated WBCs, the examination that resulted in requesting a CT scan, or the results of the CT scan. In its response to the draft report, the State argued that the PCP had followed up, and provided a reference to a document it had submitted in which it asserted a corresponding note from the PCP could be found. However, the document citation was to IView documentation, which does not include physician notes. The Monitoring Team took further steps to attempt to find the note that the State quoted, but to no avail. More specifically, for the specified date, the Monitoring Team re-reviewed the IPNs, where such a note might be found, but the Monitoring Team could not find text the State quoted.
- On 2/27/17, the PCP documented that Individual #305 was being seen due to lethargy, meal refusals, and urinary retention. It was noted that the individual's case was discussed with the epileptologist over the weekend who requested labs due to the

possibility of drug toxicity. On 2/28/17, the PCP documented that the individual's appetite was poor and there was a worsening tremor. Psychiatry added benztropine. The epileptologist was informed of the lab results. The PCP documented that this was a probable adverse drug reaction (ADR), but no ADR report was submitted. Drug levels were drawn. On 3/2/17, the Clinical Pharmacist (CP) noted that the home nurse contacted her at the request of the PCP due to a Keppra level of 59.1. The epileptologist was contacted and reportedly was not worried. On 3/3/17, the PCP wrote that the individual's status was discussed with the CP. The CP then discussed the individual's status with the epileptologist who recommended no changes until evaluation. On 3/6/17, the PCP wrote an addendum to the note indicating the individual was more alert and eating better.

On 3/21/17, a neurological consult occurred. On 3/30/17, the PCP wrote an addendum noting that the CP and epileptologist discussed the possibility of a vagus nerve stimulator (VNS). The epileptologist reportedly did not believe "that is indicated at this time and prefers medical management." There appeared to be a significant amount of informal consultation with the epileptologist for which there was no written documentation. It was concerning that the PCP would implement recommendations from the epileptologist that the CP relayed. The PCP should discuss recommendations directly with epileptologist.

c. through h. For seven of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #166 (shortness of breath on 1/6/17), Individual #277 (aspiration pneumonia on 12/6/16, and pneumonia on 1/26/17), Individual #355 (scrotal laceration on 9/30/16), Individual # 88 (right hip fracture on 12/31/16), Individual #287 (influenza/pneumonia on 1/17/17), Individual #305 (intractable seizures on 10/21/16, and intractable seizures on 10/28/16), and Individual #119 (asthma exacerbation on 11/2/16, and pneumonia in March 2017).

On 3/29/17, the PCP documented that Individual #186 was being referred to the ED for evaluation of inguinal/perineal purple ecchymosis. She was admitted with fecal impaction and hyponatremia. However, in the documents provided, sufficient documentation was not yet available to assess this hospitalization.

c. The acute events that met this criterion were for Individual #166 (shortness of breath on 1/6/17), Individual #277 (pneumonia on 1/26/17), Individual #355 (scrotal laceration on 9/30/16), Individual #305 (intractable seizures on 10/28/16), and Individual #119 (pneumonia in March 2017).

d. The acute events that met this criterion were for Individual #166 (shortness of breath on 1/6/17), Individual #277 (pneumonia on 1/26/17), and Individual #305 (intractable seizures on 10/28/16).

e. The individuals reviewed that received timely treatment at the SSLC were Individual #166 (shortness of breath on 1/6/17), Individual #277 (pneumonia on 1/26/17), Individual #355 (scrotal laceration on 9/30/16), Individual #287 (influenza/pneumonia on 1/17/17), and Individual #305 (intractable seizures on 10/28/16).

g. Based on the lack of post-hospitalization ISPA documentation, it was of concern that IDTs did not meet to discuss the hospitalizations, and identify, as appropriate, medical and healthcare supports to reduce risks and promote early recognition of concerns.

h. It also concerning that often PCPs had not 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.

The following provide examples of concerns noted:

- On 1/6/17, the PCP documented that on 1/5/17, Individual #166 "was noted to have rapid shortness of breath." The individual was transferred to the ED due to "hyponatremia (Na 125) rapid heart rate (110) and pulmonary problem." On 1/9/17, Individual #166 returned with diagnoses of left lower lobe pneumonia, and left pleural effusion, with 600 cubic centimeters (cc) removed. On 1/11/17, the PCP wrote a follow-up note that provided no information regarding the hospital diagnosis or the individual's current status. The plan was to follow the individual once a week and have labs done. On 1/13/17, nursing staff documented that the PCP was notified that the individual had decreased oxygen saturation and labored breathing. A chest x-ray was ordered. The PCP did not document an assessment. With regard to a PCP assessment, a nursing note merely stated: "[PCP] visited and assessed him." Nursing staff documented that the chest x-ray now showed a right pleural effusion. The next PCP documentation was on 1/26/17.
- On 12/4/16, nursing staff documented that the PCP was notified that Individual #277 was coughing with upper lung congestion. The plan was to monitor for residuals. The PCP documented that he was notified at 2:30 p.m. of phlegm production in the morning. The nurse requested a chest x-ray, but the PCP declined. There was no documentation of a medical assessment. On 12/5/16, another PCP noted that nurses noticed "excessive secretions from mouth and worried that he may have a lung infection." The diagnosis was "normal exam." On 12/6/16, the PCP noted the individual had difficulty breathing around 8:30 a.m. with oxygen saturation rates of 86%. The individual was sent to the hospital. Although this was during normal business hours, the PCP did not conduct an evaluation. The PCP documented later that the hospital physician indicated the individual's "condition is not good" and "critical."

  On 12/12/16, the individual returned to the Center, and on 12/13/16, the PCP saw him. The hospital diagnosis was aspiration pneumonia. On 12/14/16, the PCP wrote a three-line post-hospital note. There was no physical exam or lung auscultation. The note indicated Individual #277 was doing well and the plan was "Keep off from O2 and see how does." It was unclear what this meant. On 12/15/16, the next PCP entry was related to a head injury. There was no mention of the individual's respiratory status. On 12/15/16, different physicians wrote multiple notes. One noted an ISPA meeting, and another documented that the oxygen could be discontinued. None of these documented an actual assessment of the individual's pulmonary status.
- Also with regard to Individual #277, on 1/26/17, the PCP documented that a call was received about a critically low blood pressure (84/50). The individual was transferred to the ED for evaluation of hypotension, hypothermia, and possible sepsis since he was recently treated with clindamycin for an abscess. The individual was admitted with pneumonia, and on 1/29/17, returned to the Center. On 1/30/17, there was no MD documentation of an evaluation. A nursing note merely stated: "[PCP] visited and assessed the individual and reviewed the hospital discharge note." On 1/31/17, the PCP documented that the individual had multiple episodes of coughing after feeding. He also had vomited and became more short-of-breath. He was transferred to the hospital. It also should be noted that on 1/31/17, nursing staff documented that a recent chest x-ray showed an eight-centimeter mass in the middle lobe of the right lung of unknown etiology.
- On 12/31/16 at approximately 11:20 p.m., Individual #88 reportedly fell, and was having difficulty standing. The PCP was

contacted, and gave an order to give him ibuprofen and "put the individual in a wheelchair until [the PCP] see[s] him tomorrow." On 1/1/17 at approximately 10:00 a.m., the PCP documented that the individual complained of pain, was unable to walk, and expressed pain upon palpation of the right hip. The plan was to obtain an x-ray. At approximately 3:00 p.m., which was 16 hours after the initial complaint of pain, the individual was transferred to the hospital after the x-ray showed a right femur neck fracture. Per hospital records, Individual #88 underwent right hip hemiarthroplasty and experienced acute hypoxemic respiratory failure and ventilator dependence likely due to post-operative aspiration. On 1/16/17, Individual #88 returned to the Center. The PCP did not document any follow-up. In fact, the only two IPN entries were related to two orthopedic follow-up consults.

- On 1/17/17 at approximately 2:27 p.m., nursing staff documented that Individual #287 was coughing and not eating at the start of lunch. The PCP was asked to evaluate him, but the individual had already gone to work. At 9:19 p.m., nursing staff documented the individual was being monitored. There was no documentation of a physician evaluation. Nursing staff documented that the PCP prescribed Sudafed. On 1/23/17 at approximately 3:52 a.m., nursing staff noted Individual #287 had a non-productive cough. At 10:55 a.m., nursing staff documented that the PCP was notified "of alteration in individual baseline, nodding off sitting in chair, odd breathing pattern with gagging-like breath." A flu screen was ordered and returned positive. The individual was transferred to the ED at 10:55 a.m. At 5:30 p.m., the PCP wrote a note indicating that the PCP examined the individual at the nurses' station at 10 a.m. prior to the transfer. On 1/31/17, Individual #287 returned to the Center, and the PCP saw him. The discharge diagnoses were Influenza B, community acquired pneumonia, and atrial fibrillation. The PCP did not provide any documentation of additional follow-up. However, the last IPN the Center provided in response to the Monitoring Team's initial request was dated 2/1/17. After the Monitoring Team questioned this (i.e., because on 3/5/17, Individual #287 died at the age of 53), the Center later "found" additional IPNs and submitted them to the Monitoring Team. However, these additional IPNs were not used for the purposes of the review, because it was unclear why they were not part of the record that the Center originally provided.
- On 10/21/16 at approximately 9:00 a.m., nursing staff documented that Individual #305 had multiple seizures. The PCP was contacted and ordered intramuscular (IM) Versed. On 10/22/16, nursing documentation indicated that the individual had a series of seizures starting at 3:38 a.m., and nursing staff attempted to contact the on-call MD, who was reached at 6:30 a.m. and gave orders to transfer the individual to the ED. On 10/23/17 at 5:27 p.m., the PCP documented a note indicating the individual was transferred the previous day and would be returning back to the Center. On 10/24/16, the PCP saw the individual, and the assessment was frequent medication refusals leading to seizures. The plan was to follow-up with neurology. On 10/25/16, the PCP noted the individual was on the Onfi protocol. The IHCP did not discuss this protocol. The plan was to follow-up as needed, unless this persists or worsens.

  Again on 10/28/16, Individual #305 was transferred to the ED due to "seizures that did not abate after use of the epileptologist protocol for use of Versed." A provider saw him prior to the transfer. The Onfi protocol that the PCP referred to multiple times was not documented in the IHCP.

  On 10/29/16, Individual #305 returned from the ED, and the PCP saw him. The PCP noted that hospital staff were unaware that the individual was started on Onfi, which called into question whether or not the Center sent correct and complete information. This PCP questioned the use of Versed for breakthrough seizures noting "continue current regimen of multiple anti-seizure meds with Midazolam ? Versed for breakthrough."

On 10/30/16 at 12:45 p.m., Individual #305 returned to the ED. He also was admitted to the hospital from 11/4/16 to 11/5/16.

Per the Versed package insert, "regardless of route, continuous cardiac and respiratory monitoring is required" with the use of this medication. It is not clear that this occurred, or that the Center has the resources to provide such monitoring. This issue has been raised with State Office.

- On 11/2/16 at approximately 2:03 p.m., the PCP documented that he was notified that Individual #119 had loud wheezing that morning. Upon assessment, the PCP could hear audible wheezing from 10 feet away. The physical exam confirmed loud wheezing and grunting in all fields. No vital signs were included in this assessment. The PCP ordered a second breathing treatment. The PCP was notified that the individual had no further wheezing after the second treatment. The plan was "f/u [follow up] prn [pro re nata, or as needed]." At 7:00 p.m., the PCP documented an addendum stating that he was in the home for another reason and was notified that the individual was sent to the ED. At 4:24 p.m., a note from another PCP documented that the individual was sent emergently to the ED for possible respiratory failure.

  The first PCP clearly documented that the individual had loud audible wheezing. Pulse oximetry and respiratory rate were not documented. It did not appear that the PCP examined the individual after the second treatment, because the PCP documented that it was reported the individual had no further wheezing. It is very problematic that a physician did not auscultate the chest after the second treatment (given the severity of the initial findings). A complete resolution of all wheezing is often seen when there is insufficient air exchange to result in audible wheezing. This might be a sign of impending respiratory failure.

  On 11/2/16, Individual #119 returned to the Center, and on 11/3/16, the PCP saw her. The diagnosis was transient asthma exacerbation, and again the plan was "f/u prn." The next PCP documentation was on 2/6/17.
- Again, for Individual #119, on 3/10/17, nursing staff documented that the PCP was "informed of wheezing this morning." No new orders were given. On 3/14/17, nursing staff documented that the Respiratory Therapist reported wheezing at times since last Tuesday despite treatments being given as ordered. The PCP was notified of this, and agreed with continued treatments and keeping the individual home from programming. The PCP did not conduct and/or document an evaluation. Nursing staff continued to document intermittent wheezing. On 3/15/17, nursing staff documented: "informed MD of intermittent wheezing x [times a] week. Recommend CXR [chest x-ray]." On 3/16/17, nursing staff initiated the emesis protocol. On 3/19/17, nursing staff notified the PCP of green sputum and nasal drainage with expiratory wheezing. The PCP ordered a chest x-ray, and continued treatments. Again, the PCP conducted no assessments. At approximately 7:00 p.m., nursing staff documented that the chest x-ray showed infiltrates, and the individual had wheezing that could be heard across the room. Individual #119 was transferred to the ED. At 10:48 p.m., the PCP wrote a note related to the transfer. This was an after-hours transfer.

  On 3/23/17, Individual #119 returned to the Center. The diagnosis was pneumonia. The PCP noted that the individual was "difficult to wean from respirator." The plan was: "Follow Recovery. On 3/25/17, the PCP's note read: "S [subjective] - Notified of no problems today; PE [physical exam] - chest scattered rhonchi, heart rr [regular rate and rhythm]; vital signs inserted [sic]; A [assessment] Recovered from pneumonia; P [plan] f/u prn."

While the PCP documented assessments on two consecutive days, the documentation was woefully inadequate and provided little information to the IDT related to the individual's hospitalization and current status. Medical care plans such as follow-up prn and "follow recovery" are not consistent with current generally accepted standards. Moreover, on 3/25/17, the exam continued to demonstrate scattered rhonchi. Given the individual's history, additional medical follow-up was warranted.

In addition, the Center did not provide a hospital discharge summary. However, the hospital liaison notes provided no documentation that the individual was placed on a respirator.

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

Summary: Since the last review, it was good see improvement with regard to PCPs indicating agreement, or if PCPs disagreed with recommendations, providing a rationale and plan. The Center needs to focus on ensuring PCPs conduct reviews timely, write IPNs that included the components State Office policy requires, and refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 186	166	277	355	88	194	287	305	119
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	93% 14/15	2/2	2/2	2/2	2/2	2/2	1/1	1/2	2/2	N/A
b.	PCP completes review within five business days, or sooner if clinically indicated.	60% 9/15	1/2	1/2	2/2	0/2	2/2	0/1	1/2	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.	53% 8/15	0/2	0/2	2/2	2/2	0/2	1/1	1/2	2/2	
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	93% 14/15	2/2	2/2	2/2	2/2	2/2	1/1	1/2	2/2	
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/3	0/1	0/2	N/A	N/A	N/A	N/A	N/A	N/A	

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #186 for rheumatology on 1/5/17, and neurology on 2/22/17; Individual #166 for pulmonary on 3/17/17, and pulmonary on 11/14/16; Individual #277 for renal on 11/14/16, and podiatry on 11/17/16; Individual #355 for urology on 10/13/16, and podiatry 9/16/16; Individual #88 for ophthalmology on 10/18/16, and orthopedics on 1/31/17; Individual #194 for ear, nose, and throat (ENT) on 10/7/16; Individual #287 for eye on 11/29/16, and cardiology on 11/28/16; and Individual

#305 for epileptology on 3/21/17, and epileptology on 11/15/16 .

a. It was positive that PCPs generally reviewed the consultation reports the Monitoring Team reviewed, and indicated agreement or disagreement with the recommendations. The exception was the consultation for Individual #287 for eye on 11/29/16, for which the Center did not submit the consultation report.

b. The reviews that did not occur timely were for Individual #186 for rheumatology on 1/5/17; Individual #166 for pulmonary on 11/14/16; Individual #355 for urology on 10/13/16, and podiatry 9/16/16; Individual #194 for ENT on 10/7/16; and Individual #287 for eye on 11/29/16.

c. Approximately half of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exceptions were for Individual #186 for rheumatology on 1/5/17, and neurology on 2/22/17; Individual #166 for pulmonary on 3/17/17, and pulmonary on 11/14/16; Individual #88 for ophthalmology on 10/18/16, and orthopedics on 1/31/17; and Individual #287 for eye on 11/29/16.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of the following: Individual #287 for eye on 11/29/16, for which the Center did not submit the consultation report.

e. Problems noted included:

- It was likely that Individual #186 would need sedation to complete the study the neurologist recommended, and so this recommendation should have been referred to the IDT for review and it was not. The recommendation was to obtain a brain MRI. The PCP agreed, but at the close of the record request, the study had not been completed.
- For Individual #166, the PCP's summary in the IPN provided little useful information for the IDT. For example, the reason for this pulmonary consult, dated 2/14/17, was simply stated as: "recurrent effusion." The recommendation was "thoracentesis." The IDT requires more than two-word documentation to understand the significance of the consult and the recommendation. During the ISPA meeting, it was clear that the IDT was unaware of the significance of the problem, the treatments that were implemented, and how this all impacted the individual.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: Significant work was needed to ensure that for individuals' chronic or at-risk conditions, medical assessments, tests, and evaluations consistent with current standards of care were completed, and PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	Individual with chronic condition or individual who is at high or	22%	1/2	1/2	0/2	0/2	0/2	0/2	1/2	1/2	0/2

	medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	4/18									

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #186 – diabetes, and other: lupus; Individual #166 – other: hyponatremia, and constipation/bowel obstruction; Individual #277 – GI problems, and osteoporosis; Individual #355 – seizures, and cardiac disease; Individual #88 – osteoporosis, and infections; Individual #194 – other: kidney disease, and osteoporosis; Individual #287 – infections, and other: hypothyroidism; Individual #305 – osteoporosis, and diabetes; and Individual #119 – respiratory compromise, and other: hypertension).

a. For the following individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #186 – diabetes, Individual #166 – constipation/bowel obstruction, Individual #287 – other: hypothyroidism, and Individual #305 – diabetes.

The following provides examples of concerns noted:

- For Individual #186, on 10/6/16, the PCP commented that lupus was suspected based on a rheumatology consultation that was requested some time ago, and for which there appeared to be a delay. On 1/5/17, a consult requested serological evaluation, and there was a PCP IPN to address this consult. According to nursing staff, a follow-up occurred on 3/6/17, and the recommendation was to start Plaquenil. Plaquenil is an immunosuppressive agent that is utilized in the treatment of rheumatological disorders including lupus, and rheumatoid arthritis. On 3/7/17, the IDT met to discuss the 3/6/17 consult, and Plaquenil was ordered pending the PCP's review of lab work. The labs were not requested in a timely manner. On 3/9/17, nursing staff documented that the PCP was contacted to determine if the labs had been reviewed, and the PCP responded that they were still waiting for comprehensive lab results. On 3/15/17, nursing staff documented that the PCP was contacted and reminded that rheumatologist recommended Plaquenil. The nurse documented: "PCP stated he does not want the individual to be on the medication." Follow-up was scheduled for 7/6/17. The PCP provided no further documentation after the January consult and the recommendation was not implemented. The PCP did not document any of the lab results, assessment, or plan of care in the IPNs. The PCP provided the IDT with no information related to the diagnosis or the need for treatment.
- Individual #166 had chronic hyponatremia. There was no evidence that a thorough workup was done. The PCP documented a sodium of 125 and a urine osmolality of 129. The algorithm for evaluation of hyponatremia begins with assessing symptoms, determining serum osmolality, and assessing volume status and urine sodium and osmolality. This individual likely had hyponatremia due to medication, but the proper evaluation should be documented. A referral should be made to nephrology, if significant hyponatremia persists. Nephrology evaluation is particularly important if the PCP decides that the hyponatremia is significant enough to warrant administration of salt tablets.
- For Individual #277, a colonoscopy completed on 2/6/14 revealed three colon polyps. The pathology report included the diagnosis of tubular adenoma with low grade dysplasia. Neither the AMA nor the Active Problem List included this diagnosis. The records should clearly document the number of polyps, size of polyps, and the pathologic classification. The timeframe for repeat surveillance also should be clearly noted, particularly given the physician turnover associated with the care of this individual.
- The Plan of Care section of Individual #355's AMA documented that the lipid panel had responded to medical therapy. However, due to weight loss, his calories were greatly increased with a corresponding blunting of the response to Simvastatin.

The September 2016 lipids were reported in the AMA, and the plan was to continue medication and consider a dosage increase. There was no follow-up lipid panel, and the plan did not include any discussion of atherosclerotic cardiovascular disease (ASCVD) risk scores. Decisions related to statin use should include consideration of the risk scores.

- Individual #88's AMA simply documented a history of latent tuberculosis infection (LTBI). There was no documentation of the history of treatment (or no treatment). There was no medical care plan related to this problem, nor was there any discussion in the IRRF/IHCP. The plan for surveillance should be documented and include how staff are to monitor for signs and symptoms of active TB and the need to complete an annual TB questionnaire.
- According to Individual #88's AMA, the individual received a diagnosis of osteoporosis this year and was on Prolia and Vitamin D. The DEXA was actually done on 7/6/15, and showed precocious osteoporosis of the left hip and osteopenia of the lumbar spine. The radiologist recommended follow-up in one to two years of the hip findings. One-year of lab reports did not include a vitamin D level. It was unclear if his Vitamin D level was adequate. Also, it was not clear when treatment for osteoporosis started given the comments in the AMA, and the fact that the original IRRF did not cover osteoporosis. Of note, in January 2017, Individual #88 sustained a right hip fracture.
- Although Individual #194 had significant kidney disease, the PCP's assessment of the disease could not be determined. The Center did not submit a complete AMA and the most recent interim medical review was dated 5/27/16. No nephrology consults were submitted for this individual. Neither the IRRF nor the IHCP addressed the kidney disease.
- The Plan of Care section for Individual #305's AMA stated: "DEXA scans will be ordered every 3-5 years unless physical conditions do not allow the DEXA scan." Treatment included vitamin D and Prolia. The AMA did not include the current status/assessment. It was unclear why the plan was to obtain a DEXA scan in three to five years. The DEXA report (i.e., dated 2/25/15) noted a diagnosis of osteoporosis and the recommendation was to repeat the scan in one to two years. It did not appear the test had been repeated in February 2017.
- According to Individual #119's AMA, she currently was prescribed maximum medical therapy for asthma, which was to continue. The assessment component of the AMA did not provide any indication of the asthma severity or the disease management. Based the documentation reviewed, the individual appeared to have persistent asthma. Asthma management should be based on a stepwise therapeutic approach. It was not clear that a stepwise approach to asthma management was implemented. Even though the individual had poorly controlled asthma, there was no evidence of pulmonary consultation during the review period.
- Individual #119's AMA documented hypertension as an active problem. This diagnosis was also listed in three interim medical reviews. The status was not documented and the plan was stated as "continue current care." The Monitoring Team could not determine how this condition was being treated, or if the diagnosis was accurate.

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/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall	186	166	277	355	88	194	287	305	119

		Score									
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	33% 6/18	0/2	1/2	2/2	0/2	0/2	0/2	2/2	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. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs.											

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	186	166	277	355	88	194	287	305	119
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: Since the last review, it was good to see improvement with regard to the timely completion of QDRRs. The Center should continue to focus on the quality of the QDRRs. In the future, the Center should provide the Monitoring Team with the correct documentation to show whether or not providers reviewed QDRRs timely, and either agreed with the recommendations, or provided clinical justification for any disagreements.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2

b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	67% 12/18	0/2	2/2	2/2	2/2	0/2	0/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	72% 13/18	0/2	0/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2
	iv. New generation antipsychotic use; and	92% 11/12	2/2	1/2	N/A	N/A	2/2	2/2	N/A	2/2	2/2
	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.	22% 4/18	2/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	29% 4/14	2/2	2/2	0/2	N/A	0/2	0/2	N/A	0/2	0/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	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: b. Some of the concerns noted included: abnormal labs that were not addressed; and a lack of recommendations to address polypharmacy.

c. The documentation the Center provided did not include the providers' signatures or the determination of whether or not the providers agreed with the recommendations. While on site, the Monitoring Team requested the correct documentation. However, Center staff provided documentation for other individuals (i.e., not the nine individuals reviewed).

d. This score of 100% is misleading. In a number of cases, the Clinical Pharmacist should have made recommendations, but did not. In addition, as noted above, the Center did not provide documentation to show whether or not the providers agreed with the Clinical Pharmacist's recommendation(s).

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	186	166	277	355	88	194	287	305	119
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9	0/1	0/1	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% 0/9	0/1	0/1	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The Monitoring Team reviewed nine individuals with medium or high dental risk. None had clinically relevant, achievable, and measurable goals/objectives related to dental. c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.										

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	Individuals have no diagnosed or untreated dental caries.	56% 5/9	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	periodontal disease), improvement occurred, or the disease did not worsen.										
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	67% 6/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									
Comments: a. and b. For some individuals reviewed, because up-to-date dental exams and/or x-rays were not completed, evidence was not available to confirm that they had no untreated dental caries, and/or determine the status of their periodontal condition. c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.										

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: The Center needs to make improvements with regard to the provision of dental care and treatment.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	56% 5/9	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	44% 4/9	1/1	0/1	1/1	0/1	0/1	1/1	1/1	0/1	0/1
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.	67% 6/9	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	25% 1/4	1/1	N/A	0/1	N/A	N/A	N/A	N/A	0/1	0/1
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	22% 2/9	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 2/2	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments: a. through f. A number of individuals reviewed had not had needed dental treatment.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: Given that over the two other review periods and during this review (these indicators were not applicable in Round 10), individuals with dental emergencies had dental services within 24 hours (Round 9 – 100%, Round 11 – 100%, and Round 12 - 100%), had needed treatment (Round 9 – 100%, Round 11 – N/A, and Round 12 - 100%), and had pain management, as needed (Round 9 – 100%, Round 11 – N/A, and Round 12 - 100%), Indicators a, b, and c will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 2/2	N/A	N/A	N/A	N/A	N/A	2/2	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 2/2						2/2			
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 2/2						2/2			
Comments: a. through c. For the individual reviewed for which two dental emergencies occurred, the Dental Department provided emergency dental care in a timely manner.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	25% 1/4	N/A	N/A	1/1	0/1	0/1	N/A	0/1	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/1			0/1	N/A	N/A		N/A		
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/1			0/1	N/A	N/A		N/A		
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/1			0/1	N/A	N/A		N/A		

	Comments: a. Three of the individuals reviewed should have had assessments to determine the need for suction tooth brushing, but did not.

Outcome 9 – Individuals who need them have dentures.											
Summary: During this review and the last one, the Center showed improvement with regard to Indicator a. If this progress is sustained, this indicator might move to the category requiring less oversight at the time of the next review.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
	Comments: a. For the individuals reviewed with missing teeth, the Dental Department generally assessed them 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 areas on which the Center needs to focus. Although some improvement was noted since the last review, 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. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed significant improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	30% 3/10	N/A	1/1	1/2	N/A	0/2	N/A	1/2	0/2	0/1
b.	For an individual with an acute illness/occurrence, licensed nursing	60%		1/1	1/2		2/2		1/2	1/2	0/1

	staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	6/10									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/4		N/A	0/1		0/1		0/1	0/1	N/A
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/6		0/1	0/1		0/1		0/1	0/1	0/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/10		0/1	0/2		0/2		0/2	0/2	0/1
f.	The individual's acute care plan is implemented.	0% 0/10		0/1	0/2		0/2		0/2	0/2	0/1

Comments: The Monitoring Team reviewed 10 acute illnesses and/or acute occurrences for six individuals, including Individual #166 – left lower lobe pneumonia and left plural effusion on 1/9/17; Individual #277 – mild head injury on 11/8/16, and upper GI bleed on 1/8/17; Individual #277 – fall on 12/31/16, and fractured neck of right femur on 1/1/17; Individual #287 – bradycardia, hypotension, and lethargy on 11/10/16, and possible stroke on 2/21/17; Individual #305 – multiple seizures on 10/28/16, and urinary retention on 2/26/17; and Individual #119 – expiratory wheezing on 11/2/16.

a. The acute illnesses/occurrences for which nursing assessments (physical assessments) were performed were for Individual #166 – left lower lobe pneumonia and left plural effusion on 1/9/17, Individual #277 – upper GI bleed on 1/8/17, and Individual #287 – bradycardia, hypotension, and lethargy on 11/10/16.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the DADS SSLC nursing protocol entitled: "When contacting the PCP" were: Individual #166 – left lower lobe pneumonia and left plural effusion on 1/9/17; Individual #277 – upper GI bleed on 1/8/17; Individual #277 – fall on 12/31/16, and fractured neck of right femur on 1/1/17; Individual #287 – bradycardia, hypotension, and lethargy on 11/10/16; and Individual #305 – urinary retention on 2/26/17.

e. For a number of acute issues, the Center did not submit acute care plans (i.e., Individual #277 – mild head injury on 11/8/16, and upper GI bleed on 1/8/17; Individual #277 – fall on 12/31/16; Individual #287 – bradycardia, hypotension, and lethargy on 11/10/16; Individual #305 – multiple seizures on 10/28/16, and urinary retention on 2/26/17; and Individual #119 – expiratory wheezing on 11/2/16). Common problems with the few acute care plans that were submitted included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing protocols; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur.

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

- According to direct support professional staff, Individual #277 was putting his shoes on and off when he missed, fell forward,

and hit his head on the corner of his closet. Nursing staff did not follow nursing protocols/standards of care for a mild head injury and/or assessment for pain. For example, the IPN did not show assessment of the cuts (length, width, depth), and/or whether or not there was swelling. For his neurological status, documentation stated he was "alert," but it included no descriptive behaviors of his alert status or level of consciousness. Nursing staff did not notify the physician, which should have been done in accordance with the head injury protocol. Nursing staff also did not develop and/or implement an acute care plan for Individual #277.

- Similarly, upon Individual #277 return from the hospital on 1/11/17 with diagnoses of esophagitis, and hiatal hernia, nursing staff did not initiate an acute care plan. Follow-up nursing assessments did not consistently provide information regarding the new proton pump inhibitor, monitoring for side effects, or how the individual was tolerating changes to his enteral feedings.
- For Individual #88's fall on 12/31/16, a nursing IPN stated: ""Home nurse… called and said that [Individual #88} had a fall and that when… assessed [at] home he has difficulty standing up." The actual documentation of the initial assessment the RN referenced was not found in the documents provided. As a result, it did not appear that the nurse followed the fall protocol: suspect fracture/dislocation, including completion of full vital signs, condition of the extremity/joint color, size (edema) neurovascular status sensation, capillary refill, and distal pulses. The RN IPN that documented notification of the PCP indicated the RN "suggested to the physician if an x-ray could be done - he said it will not really able [sic] to show anything." Given the suspected fracture, the RN should have developed an acute care plan, but did not.

  On 1/1/17, a medical IPN documented a request for an x-ray. Individual #88 was transferred to the ED, and diagnosed with a fractured neck of the right femur. He was admitted, and underwent total hip replacement. On 1/2/17, he had a change in status, and transferred to the Intensive Care Unit (ICU) due to respiratory distress requiring ventilator support and a nasogastric tube. Upon his return on 1/16/17, the post-hospital nursing assessments did not include follow-up for statements related to his abdomen, which ranged from "normal for age/size" to distended. In addition, on 1/16/17, his Braden score was 14, which is mild risk, and on 1/17/17, his Braden score was 12, which is high risk. Nursing IPNs did not explain these changes, nor did they show reassessment of the change in status. Although nursing staff developed an acute care plan in response to his return from the hospital, it often did not define the frequency of interventions, and some interventions were marked as "done," without corresponding IPNs to substantiate they were completed.
- For Individual #287's bradycardia, hypotension, and lethargy on 11/10/16, the initial nursing assessment followed standards of care based on the urgency of the individual's signs and symptoms, which was good to see. Nursing staff promptly notified the PCP. However, on 11/11/16 at 1:18 a.m., the individual returned from the ED, but the nurse did not notify the physician of the individual's return. No new orders were found for 11/11/16. A nursing assessment, dated 11/11/16 at 6:59 a.m., documented that his "heart rate ranges from the 30's to the 70's." Review of IView post-hospital vital signs showed that on 11/11/16 at 2:58 a.m., a nurse documented vital signs, and then again on 11/11/16 at 9:30 a.m., a nurse documented the individual's heart rate in relation to medication administration. Given the complexity of Individual #287's presenting signs and symptoms that required his transfer to the ED, nursing staff should have completed more frequent assessments of his cardiac and perfusion status. Nursing staff did not develop an acute care plan, and his IHCP was not modified.
- On 10/28/16, for Individual #305's seizures, nursing staff did not conduct vital sign assessments in accordance with accepted nursing guidelines for his fourth, fifth, sixth, seventh or eighth seizures, and the two times he was administered Versed 5 milligrams. According to a quarterly nursing review, dated 1/6/17, Versed was administered seven times in the previous quarter. As noted above in the medical section, per the Versed package insert, "regardless of route, continuous cardiac and

respiratory monitoring is required" with the use of this medication. It did not appear that this occurred, or that the Center has the resources to provide such monitoring. This issue has been raised with State Office. It also was unclear whether or not the individual's medication refusals impacted his need for Versed, and if so, whether or not the IDT was addressing his refusals.

- For Individual #119, a medical IPN, dated 11/2/16 at 2:03 p.m., prior to the time she was sent to the hospital, indicated: "Notified of loud wheezing this am… Audible wheezing with grunting could be heard from 10 ft. away." The note further indicated that vital signs nursing staff had noted were pending charting. The Center did not provide the Monitoring Team with a nursing IPN to corroborate that the nurse completed vital signs or other assessments. Moreover, no acute care plan was submitted to address the need for nursing assessments of her airway management.

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.

#	Indicator	Overall Score	Individuals: 186	166	277	355	88	194	287	305	119
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.	11% 2/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	1/2	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 #186 – circulatory, and constipation/bowel obstruction; Individual #166 – respiratory compromise, and weight; Individual #277 – GI problems, and skin integrity; Individual #355 – constipation/bowel obstruction, and falls; Individual #88 – GI problems, and skin integrity; Individual #194 – dental, and GI problems; Individual #287 – fractures, and infections; Individual #305 – constipation/bowel obstruction, and seizures; and Individual #119 – respiratory compromise, and weight).

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 #166 – weight, and Individual #305 – constipation/bowel obstruction.

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 the Center's scores consistently 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: 186	166	277	355	88	194	287	305	119
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% 0/11	0/1	0/2	0/2	0/1	N/A	0/1	N/A	0/2	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	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 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: All of these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 186	166	277	355	88	194	287	305	119
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R				N/A			N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine	100%	1/1	1/1	1/1		1/1	1/1		1/1	1/1

	rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	7/7									
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/A	N/A	N/A	N/A		N/A	N/A		N/A	N/A
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	0% 0/4	N/A	0/1	0/1		0/1	N/A		N/A	0/1
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	71% 5/7	1/1	0/1	1/1		1/1	1/1		1/1	0/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 7/7	1/1	1/1	1/1		1/1	1/1		1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper	N/R									

	reporting of the variance.										
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of seven individuals, including Individual #186, Individual #166, Individual #277, Individual #88, Individual #194, Individual #305, and Individual #119.

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

d. The CNE reported that nursing staff completed training regarding lung sounds during medication administration in alignment with the indicators. It was extremely positive that during observations, medication nurses completed lung sounds for three of four applicable individuals. The exception was for Individual #119 for whom the nurse did not follow standards of practice in conducting lung sounds. The Nursing Operations Officer (NOO) and Compliance Nurse were in attendance during the observation. The NOO indicated follow-up would occur to support the nurse through additional education and opportunities for conducting lung sounds.

However, because the IHCPs did not define these assessments, the Center did not meet criteria for this indicator. Nursing staff are encouraged to continue this practice during medication passes, and RN Case Managers should ensure that individuals' IHCPs and/or acute care plans define the assessments individuals need.

f. For two individuals observed, the nurses did not review their PNMPs prior to medication administration.

g. For the individuals observed, nursing staff followed infection control practices, which was good to see.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Individuals often were not referred to the PNMT, when needed. In addition, 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	186	166	277	355	88	194	287	305	119
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% 0/11	0/1	0/2	0/1	0/1	0/1	0/2	0/1	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/11	0/1	0/2	0/1	0/1	0/1	0/2	0/1	0/1	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/11	0/1	0/2	0/1	0/1	0/1	0/2	0/1	0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/11	0/1	0/2	0/1	0/1	0/1	0/2	0/1	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/11	0/1	0/2	0/1	0/1	0/1	0/2	0/1	0/1	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	63% 5/8	0/1	N/A	0/1	0/1	1/1	1/1	1/1	1/1	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1		0/1	0/1	0/1	N/A	0/1	0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	14% 1/7	0/1		0/1	0/1	0/1		0/1	1/1	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/7	0/1		0/1	0/1	0/1		0/1	0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/7	0/1		0/1	0/1	0/1		0/1	0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1		0/1	0/1	0/1		0/1	0/1	0/1

Comments: The Monitoring Team reviewed 11 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: choking for Individual #186; choking, and weight for Individual #166; falls for Individual #277; falls for Individual #355; choking for Individual #88; choking, and falls for Individual #194; fractures for Individual #287; falls for Individual #305; and circulatory for Individual #119.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives.

b.i. The Monitoring Team reviewed eight areas of need for eight individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were

included. These areas of need included: falls for Individual #186, aspiration for Individual #277, weight for Individual #355, fractures for Individual #88, weight for Individual #194 (i.e., review with no goal development needed), aspiration for Individual #287, weight for Individual #305, and respiratory compromise for Individual #119.

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

- Despite reports of 24 falls from October 2016 through March 2017, Individual #186's IDT did not revise her IRRF or IHCP. QIDP notes quoted a Falls Risk Assessment, dated 2/3/17, that reported she had experienced one to two falls in the last three months, but other documentation submitted indicated that she had at least 16 falls during that time.
- On 12/6/16, Individual #277 was diagnosed with aspiration pneumonia. On 1/26/17, he was diagnosed with pneumonia. On 1/31/17, he had possible aspiration pneumonia. On 2/9/17, he was diagnosed with aspiration pneumonia. On 7/24/13 and 1/15/14, the PNMT assessed him. However, recently, there was no evidence of referral or formal review other than PNMT RN post-hospitalization assessments, and PNMT review of these reviews.
- Notes indicated that Individual #355 had a 10 percent weight loss from January 2016 (105.2) to April 2016 (94.8), and additional weight loss in May 2016 (93.4). In June 2016, his lowest weight was recorded as 86.2 pounds. It was not until 6/16/16 that the PNMT discovered a 7.2 percent weight loss in one month and self-referred him.

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. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: weight for Individual #305.

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 generally 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	186	166	277	355	88	194	287	305	119
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/17	0/2	0/2	0/2	0/2	0/1	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.	25% 3/12	0/2	0/1	0/2	1/2	1/1	0/1	0/1	0/1	1/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A

	between the PNMT and IDT.										

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

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

- On 7/20/16, Individual #186 sustained a serious injury to her elbow when a male peer pushed her down. No evidence was found of further IDT meetings to discuss the frequency of her falls, and to identify why she was falling in order to establish strategies to address this issue.
- On 2/27/17, Individual #277's IDT held an ISPA meeting related to a fall. At the time, he was hospitalized, and the IDT stated that his falls might be related to hypotension. The IDT indicated that they would meet again after his discharge from the hospital. However, on 3/8/17, during the ISPA meeting held post-hospitalization, the IDT did not discuss his falls. He had another fall and sustained an injury during which he reopened an existing cut over his eyebrow. The IDT agreed to add one-to-one staffing at arms-length during walking and transfers, and the use of a wheelchair as needed. Although the IDT added supports, they did not discuss the etiology of his falls.

c. For Individual #355, an ISPA, dated 12/19/16, essentially stated that the PNMT discharged him the week of 12/5/16. It did not show evidence of a comprehensive discharge process between the PNMT and IDT.

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

Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	53% 28/53	
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.	63% 5/8	

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 12 out of 31 observations (39%). Staff followed individuals' dining plans during 14 out of 20 mealtime observations (70%). Staff completed transfers correctly during two out of two observations (100%).

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: N/A			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A			N/A				N/A		
Comments: 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 the 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	186	166	277	355	88	194	287	305	119
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	30% 3/10	0/1	N/A	0/1	0/1	3/3	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	30% 3/10	0/1		0/1	0/1	3/3	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/10	0/1		0/1	0/1	0/3	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/10	0/1		0/1	0/1	0/3	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10	0/1		0/1	0/1	0/3	0/1	0/1	0/1	0/1
Comments: a. and b. Individual #166 did not have the need for formal OT/PT services or supports beyond the need for a PNMP. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #88 (i.e., supine to sitting in bed, sit to stand, and ambulation).											

c. through e. Individual #166 was part of the core group, so a full review was conducted. 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. The Monitoring Team conducted full reviews for eight individuals.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/2	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: 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%, Round 11 - 63, and Round 12 - 76%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for this indicator, scores continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	142	352	255	75	144	326	121	31	347
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									

b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	76% 22/29	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		268	281	243	227	230	260	110	59	114
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/2	0/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		226	343	331	23	239	78	217	317	314
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		174								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								
Comments: c. The Monitoring Team conducted observations of 29 pieces of adaptive equipment. Based on observation of Individual #75, Individual #347, Individual #243, Individual #227, Individual #23, Individual #78, and Individual #314 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.											

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. At the last review, two indicators were moved to the category of requiring less oversight. At this review, two other indicators, in engagement, will be moved to this category.

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

For the action plans that were in the ISPs, a majority were either never implemented, or data were not collected regularly enough to determine whether progress towards goals was or was not occurring.

Reasonable plans were in place to improve the content of the SAPs. There was also progress in the way the facility tried to ensure that SAPs were implemented correctly.

It was concerning that often when opportunities for individuals to use their AAC devices presented themselves, staff did not prompt individuals to use them.

There were overall improvements in engagement throughout the facility, such as in the sensory skills room, vocational work rooms, and in the four-room hallway in the day program building. The facility established individual engagement goals, and observed and measured in all of these sites multiple times per month. Further, the staff regularly checked inter-observer agreement, graphed the results, and provided monthly data to the managers of those sites.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: One goal met criteria with indicator 3. Implementation and data are required if this set of indicators is to be determined. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	186	166	342	179	119	355			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal	0%	0/6	0/6	0/6	0/6	0/6	0/6			

	goals.	0/6									
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

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

For the personal goals that met criterion with indicators 1 and 2, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available. The one exception was for Individual #166's greater independence goal. One of the components of his independence goal was met, but it was not updated (indicator 5).

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	186	166	342	179	119	355			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	67% 4/6	1/1	1/1	1/1	1/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. Staff knowledge regarding individuals' ISPs was sufficient for four individuals, but for Individual #119 and Individual #355, insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation. For Individual #119, staff could not consistently describe implementation of her communication supports. Individual #355 had moved prior to the Monitoring Team's visit, so staff were not interviewed, however, documentation did not support consistent implementation.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans for any of the individuals, as noted throughout this report.

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: Performance scores were almost identical to the last review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	294	304	291	118	179	166	320	186	342

		Score									
6	The individual is progressing on his/her SAPS	9% 2/22	0/3	1/2	0/2	N/A	0/3	1/3	0/3	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	50% 1/2	N/A	1/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/12	N/A	0/1	0/2	N/A	0/1	0/2	0/3	0/3	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	19% 3/16	N/A	1/2	0/2	N/A	2/3	0/3	0/3	0/3	N/A

Comments:
6. There was insufficient, but reliable, data to determine progress for Individual #118's brush teeth, wash clothes, and assemble boxes SAPs. Individual #166's unlock his wardrobe and Individual #304's wash her clothes SAPs had reliable data indicating progress. Individual #179's state the amount of change and exercise SAPs were also improving, however, they were judged not to be practical (see indicator 4) and, therefore, were scored as 0. The remaining SAPs were scored as not progressing either because the individual was not making progress (e.g., Individual #320's remove the stable SAP), or because there were insufficient data and the data were not demonstrated to be reliable (e.g., Individual #342's request the radio SAP).

7-8. Individual #304's wash her clothes SAP was achieved in March 2017, and she moved to the next step in April 2017. This was good to see. Individual #166's unlock the wardrobe SAP, on the other hand, was achieved in September 2016, but continued through March 2017. Similarly, in none of the 12 SAPs that were judged as not progressing (e.g., Individual #186's floss her teeth SAP) was there evidence that actions were taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP).

9. Overall, there appeared to be data based decisions to continue, discontinue, or modify SAPs in only Individual #304's wash her clothes SAP, and Individual #179's state the amount of change and exercise SAPs.

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

Summary: Reasonable plans were in place to improve the content of the SAPs. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
13	The individual's SAPs are complete.	0% 0/25	0/3	0/2	0/2	0/3	0/3	0/3	0/3	0/3	0/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although none of the SAPs were found to be complete, the majority of SAP components were found in all of the 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, or represented compliance issues rather than the acquisition of new skills (e.g., Individual #320's remove a staple SAP).

Another common missing component was the absence of clear SAP training instructions. In most SAPs, it was unclear if they represented total task training procedures, or were to be trained one step at a time. Additionally, the SAP training sheet did not indicate how staff are to present steps that have already been mastered, or training steps that follow the training step.

San Antonio SSLC recently began to develop a new SAP training procedure. That procedure was reviewed with the Monitoring Team, and the new SAP template appears to address the issues discussed above.

Outcome 5- SAPs are implemented with integrity.

Summary: It was good to see progress in the way that San Antonio SSLC tried to ensure that SAPs were implemented correctly (indicator 15). This recent effort, however, was not yet reflected in improvements in actual implementation (indicator 14), but continued integrity activities may result in improvement. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	291	118	179	166	320	186	342
14	SAPs are implemented as written.	25% 1/4	N/A	1/1	N/A	0/1	N/A	N/A	0/1	N/A	0/1
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.	72% 18/25	0/3	2/2	2/2	3/3	3/3	3/3	2/3	3/3	0/3

Comments:

14. The Monitoring Team observed the implementation of four SAPs. One SAP (Individual #304's wash her clothes) was judged to be implemented with integrity. The other three SAPs observed by the Monitoring Team (Individual #320's brush his teeth, Individual #118's wash his clothes, and Individual #342's request his radio SAP) were not implemented as written.

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. 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. The Monitoring Team was encouraged to see that 18 of the SAPs achieved this frequency and level of SAP integrity. This sets the occasion for improvement in actual implementation.

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

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 294	304	291	118	179	166	320	186	342

16	There is evidence that SAPs are reviewed monthly.	8% 2/25	0/3	0/2	0/2	0/3	0/3	0/3	0/3	0/3	2/3
17	SAP outcomes are graphed.	76% 19/25	0/3	2/2	2/2	3/3	3/3	3/3	3/3	3/3	0/3

Comments:
16. The majority of SAPs were reviewed in QIDP monthly reports, however, in many reviews, only one month of SAP data was presented, which did not allow data based decisions concerning the need to continue, discontinue, or modify them (e.g., Individual #186 take a shower SAP).

17. There were no data for Individual #294's SAPs. Nineteen of the remaining 22 SAPs were graphed. The exceptions were Individual #342's request his radio, choose an activity, and brush his teeth SAPs.

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

Summary: Overall, the Monitoring Team observed improved engagement across the facility. Indicators 18 and 21 scored higher than during the previous two reviews. Indicators 19 and 20 maintained 100% performance for this review and the past two reviews and, therefore, will be moved to the category of requiring less oversight. Indicators 18 and 21 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
18	The individual is meaningfully engaged in residential and treatment sites.	50% 4/8	N/A	1/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1
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.	67% 6/9	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1

Comments:
18. The Monitoring Team directly observed eight individuals (Individual #294 was in the hospital during the onsite review) multiple times in various settings on campus during the onsite week. The Monitoring Team found four (Individual #342, Individual #320, Individual #179, Individual #304) of the eight individuals to be 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 67% of the residential and day treatment sites of

the individuals achieved their goal level of engagement. Overall, the Monitoring Team noted improvements in engagement at the facility.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: It was good to see that individuals were getting out into the community. More attention to ensuring the minimal goals set for each individual are met for recreational outings as well as those that include working on one's SAPs in the community. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	294	304	291	118	179	166	320	186	342
22	For the individual, goal frequencies of community recreational activities are established and achieved.	44% 4/9	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 22-24. San Antonio SSLC established individualized goals for the frequency of community outings and SAP training in the community. Individual #186, Individual #179, Individual #118, and Individual #304 achieved their individualized community outing goals. There was not a goal for SAP training in the community for Individual #291, Individual #166, Individual #342, or Individual #320. None of the remaining individuals achieved their community SAP training goals. 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:			Individuals:								
#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 25. None of the individuals in the group selected for review by the Monitoring Team were currently attending public school. The Monitoring Team, however, reviewed Individual #351's ISP. He received educational services, and his IDT did participate in IEP meetings and exchanged educational information with the school. This was all very good to see. Individual #351's educational supports and services were not, however, 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: N/A			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: a. through e. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed had documented dental refusals.											

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 a number of the goals/objectives IDTs developed in relation to individuals' communication needs were clinically relevant and measurable. Over the past three rounds of reviews, this is an area in which the Center has consistently done fairly well. However, these indicators are necessary for the Monitoring Team to determine whether or not IDTs are able to measure outcomes for individuals. They all will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	63% 5/8	0/1	1/1	1/1	1/1	1/1	N/A	0/1	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	88% 7/8	0/1	1/1	1/1	1/1	1/1		1/1	1/1	1/1

c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1

Comments: a. and b. Individual #194 had functional communication skills. Although from Individual #186's communication screening, it appeared she had functional communication skills, her IDT indicated under communication instructions in her ISP, that she needed assistance from Speech to use the phone. The IDT did not develop a goal, or provide explanation of supports that would be provided to enhance this aspect of her communication.

The goals/objectives that were clinically relevant, as well as measurable were for Individual #166 to sign "break," Individual #277 to choose a leisure activity, Individual #355 to request music, Individual #88 to request his meal, and Individual #119 to request more batteries.

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 #287's goal/objective to nod when asked if he would like to listen to music, and Individual #305 to imitate "more," when staff asked him if he wanted a drink.

c. through e. Although the QIDP for Individual #119 completed timely monthly reviews, analysis of the data was not included. For example, in February 2017, the QIDP did not explain why staff only offered Individual #119 one opportunity. Also, in March 2017, Individual #119 suddenly had a four out of four score, but the QIDP did not discuss how/why this occurred.

As noted above, Individual #194 had functional communication skills. Individual #194 was part of the outcome group, so further review was not conducted for her related to communication. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	186	166	277	355	88	194	287	305	119
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	14% 1/7	N/A	0/1	0/1	0/1	0/1	N/R	0/1	0/1	1/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA	N/A									

	meeting is held to discuss and approve termination.										

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. Examples of concerns included:

- For many individuals, ISP integrated reviews were completed in April 2017 for the preceding six months. This was of little use to the IDTs.
- Moreover, summaries that stated: "in process," provided no analysis of the implementation of communication programs.
- In a number of instances, the QIDP summaries provided no evidence that the communication programs were implemented.
- In reviewing data sheets submitted, sometimes it appeared the program had been implemented, and in other cases, no data were included.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.

Summary: The Center should focus on ensuring that staff prompt individuals to use their AAC devices in a functional manner. Indicator b will remain in active monitoring.

[**Note:** due to the number of individuals reviewed for this indicator, scores continue below, but the total is listed under "Overall Score."]

#	Indicator	Overall Score	Individuals: 352	280	302	281	121	258	284	18	243
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	40% 6/15	0/1	0/1	0/1	1/2	1/2	1/1	1/1	0/1	0/1
			Individuals:								
#	Indicator		230	215	332	119					
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	0/1	0/1					
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	33% 2/6									

Comments: a. and b. It was concerning that often when opportunities for using the AAC devices presented themselves, staff did not prompt individuals to use them.

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight, though with sustained high performance, a number of the indicators might be moved to this category after the next review.

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.

Three individuals transitioned since the last Monitoring Team review (one occurred during the onsite week). Ongoing changes in the staffing of the admissions and placement department competed with the department's ability to move forward and progress in meeting the criteria for these outcomes and indicators. Much work was needed to create CLDPs that contained comprehensive lists of pre and post move supports that addressed all of the important aspects of the individual's needs and preferences. In particular, there was an absence of supports related to community provider staff training, knowledge, and competency Moreover, all of the supports need to be written in terminology that allows them to be measurable.

It was good to see that IDTs were actively involved in the individual's transition, including visiting the new sites and ensuring various environmental aspects were addressed prior to his move.

Post move monitoring was occurring as required and, for the most part, done diligently. Some additional activities to ensure that each support was being provided were necessary. Similarly, more work was needed to improve the transition assessments so that they would be most useful to the IDT in planning for transition (and in developing a comprehensive CLDP) and to the new provider. Even so, IDTs were involved in the transitions of individuals, visiting sites and assisting in transition activities.

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 CLDP contained a relatively small number of pre and post move supports. The Monitoring Team's review found many preferences and needs of the individual that were not included in the list of supports. Much work needs to be done to ensure that the list of supports is comprehensive and individualized, and that the supports are worded in a way that makes them measurable. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	188								

		Score									
1	The individual's CLDP contains supports that are measurable.	0% 0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/1	0/1								

Comments:
One individual's transition was reviewed for monitoring of the outcomes and indicators in this domain because only one individual was reported to have transitioned during the review period. While onsite, the Monitoring Team learned that a second individual had transitioned Individual #65, and a third individual transitioned on the Monday of the onsite review week (Individual #47).

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how needs and preferences must be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. For this CLDP, many supports were not yet written in measurable terminology and, therefore, did not provide the Post Move Monitor with measurable criteria or indicators that could be used to ensure supports were being provided as needed.

The IDT developed three pre-move supports for Individual #188. The pre-move supports called for the San Antonio SSLC Admissions and Placement Coordinator (APC) to deliver a copy of Individual #188's 90-I and any documentation required to assist in his application for Social Security to the provide case manager by the day of move, and for a dining chair with arm rests, and for a shower chair to be available. The Monitoring Team noted that the CLDP did not contain all necessary pre-move requirements, specifically, that it did not define any required pre-move provider training, knowledge, or competence.

The IDT developed 32 post-move supports for Individual #188. Six supports for receiving various health care appointments and exams were measurable, as were two supports for administration of medications, and two supports for communication strategies. It was positive to see that interviews with provider staff and with Individual #188 were typically included as required evidence, in addition to documentation. Examples of post-move supports that did not meet criterion for measurability included:

- One of the three supports for medication administration called for Individual #188 to receive his medications as prescribed and that he took his medications whole with water. The support listed his medications by dosage and when taken. It indicated Individual #188 received Fosomax 70 mg once a week, but did not state the instructions, per the Integrated Risk Rating Form (IRRF,) that it needed to be given on an empty stomach with at least 6 oz. of water and separated from other medications and food by at least 30 minutes. This was to aid absorption and decrease GI ulceration.
- A support stated the provider Registered Nurse (RN) would document weight monthly and provide any follow-up if weight fluctuated dramatically. The support did not provide a baseline or indicate what might constitute a dramatic fluctuation. This was of concern because Individual #188 had an unplanned weight loss of 13 pounds over four months at the end of 2016. The CLDP narrative noted a nutrition assessment dated 1/4/17 that indicated the IDT had met on 12/16/16 to discuss, but concluded the weight loss was probably due to overmedication that had been addressed. The CLDP did not make clear what his weight status was at the time of the CLDP on 2/21/17 or at the time of discharge, but the 45-day PMM Checklist indicated his weight was 190 pounds, down from 194.7 at the time of the nutrition assessment referenced in the CLDP. Upon review of the assessment, he had continued to lose weight. The assessment indicated he weighed 206 pounds in September 2016, so by the

time of the 45-Day, he had lost 16 pounds, with the downward trend continuing.

- It was positive that the IDT developed a support to check Individual #188's skin at least weekly due to his history of MRSA cellulitis, but the support did not specify what symptoms staff needed to be alert for, how the skin checks would be documented, or what action to take if skin changes were identified.
- Given Individual #188's specific risk for developing hyponatremia and requirement for a low-sodium diet, his two related supports to provide options for a healthy regular diet and readily available healthy snack options did not provide staff with the needed description of what healthy meant for him.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place for this indicator to be scored as meeting criterion. The Center had identified many supports for Individual #188 and it was positive they had made a diligent effort to address his needs. Despite these efforts, the CLDP did not comprehensively address all of his support needs and, therefore, did not meet criterion. In addition to those identified above under Indicator 1, other examples included the following:

a. Past history, and recent and current behavioral and psychiatric problems: Supports did not sufficiently reflect Individual #188's past history, and recent and current behavioral and psychiatric problems in a consistent manner. Examples included:
    - Individual #188 had a history of aggressive behavior and depression. The behavioral assessment indicated Individual #188 had been doing well behaviorally for the past year and his Positive Behavior Support Plan (PBSP) had been discontinued in favor of a Psychiatric Support Plan (PSP). Behavioral supports included that the San Antonio SSLC psychiatrist and Board Certified Behavior Analyst (BCBA) would be available to the provider for consultation on an as-needed basis and that Individual #188 would see a community psychiatrist within 90 days of transition. The CLDP, however, did not have any supports for staff knowledge of Individual #188's behavioral history, particularly since the psychiatric assessment materials indicated his aggressive behaviors were episodic and sporadic in nature, with intervals lasting potentially for years. Further, a quarterly psychiatric note, dated 2/8/17, stated he had been more irritable and more attention seeking, with refusals to go to work and bizarre behavior in the past few weeks just prior to the CLDP meeting.
    - The CLDP did not include a support for staff knowledge of the PSP, including, for example, knowledge of psychiatric supports or his psychiatric indicators of aggression, appetite increase or decrease, lack of interest in preferred activities, and not interacting with others. The CLDP supports also did not include any requirement for tracking these indicators.
    - Both the vocational assessment and social assessments stated Individual #188 needed a structured work station and a smaller, quieter environment with behavioral health support to monitor and provide intervention strategies for aggression. An ISPA held during the transition period indicated he also needed a smaller and quieter day habilitation program. An ISPA, dated 1/3/17, indicated he did not respond well to the first day habilitation program, stating it was too big and he needed to attend the smaller CDO program until a suitable replacement could be found. The CLDP narrative included a recommendation that he attend CDO, with no further discussion about his need for a suitable replacement. The supports did not address any day habilitation program or behavioral supports needed in such a setting.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: Examples included:

- The CLDP did not include a support defining staff supervision needs. The narrative indicated he did not require any special supervision due to behavioral concerns, but that he was unable to access the community independently and needed staff supervision and assistance when away from home. This did not make clear what his routine supervision needs were in the home. It was positive that supports were identified for some specific supervision needs in the home, such as assistance with medications, prompting to complete personal grooming, and prompting to not wear the same clothes every day, but these were not all-inclusive of his needs for staff assistance and supervision. For example, the vocational assessment stated Individual #188 disregarded all hazards when upset, which would have been important knowledge for staff. The Monitoring Team noted the PMM Checklist did include an additional support that was not in the CLDP stating Individual #188 would have ready access to direct care staff to help him become familiar with his new home and neighborhood. In interview, transition staff indicated they made this change based upon their assessment it was needed. It was positive to see that transition staff paid attention to, and sought to correct, any oversights they identified. It remained important for the IDT to be centrally involved in the process of supports development and approval.
- The medical assessment, dated 1/17/17, did not provide current status and recent history as needed. For example, in the section labeled active, all the laboratory values reported were all from 2014. The CLDP did not include recommendations or supports regarding needed laboratory tests. A support called for Individual #188 to see the community physician within 30 days to ensure continuity of medical care, but should have specified what needed to be continued and why, based on the knowledge the IDT had regarding his needs.
- The CLDP did not include any staff training or knowledge about his medical diagnoses, including benign prostatic hypertrophy/overactive bladder and restrictive lung disease. Provider staff needed to be aware of diagnoses and how these might manifest in symptoms. For example, as it related to his diagnosis of restrictive lung disease, Individual #188 had experienced recurrent pneumonia for which he was hospitalized three different times within the past three years.
- Individual #188 had an unsteady gait and a recent history of falls, but the CLDP did not have any supports for this issue. Per his ISP and IRRF, Individual #188 had fallen five times in the year leading up to his July 2016 ISP. The nursing discharge assessment, dated 1/13/17 and IHCP review dated 1/17/17 indicated he was being monitored during the quarter for falls and unsteady gait, but stated it was unclear if this was behavioral or medical in nature. It also noted three falls had occurred during the quarter. The CLDP narrative did indicate that the IDT determined that falls were due to medication issues that had been resolved, but staff should have been trained as to the history and risk of falls and how to monitor for possible recurrence of over-medication.
- Per the IRRF, Individual #188 was at high risk for side effects due to 1) the likely presence of medication related side effects, 2) the need for high dose therapy, 3) the presence of medication interactions, 4) the long-term use of a scheduled benzodiazepine, 5) the moderate anticholinergic burden, and 6) the presence of polypharmacy. The IRRF further noted the concurrent use of fluoxetine and valproic acid could result in an increased risk of the development of syndrome of inappropriate antidiuretic hormone secretion (SIADH), which may cause hyponatremia. Signs and symptoms of hyponatremia included anorexia, nausea, and malaise are the earliest findings, followed by headache, irritability, confusion, muscle cramps, weakness, obtundation, seizures, and coma. The IRRF stated Individual #188 was routinely monitored for signs and symptoms of hyponatremia, but the CLDP included no supports for staff

knowledge or monitoring of side effects.

- The medical assessment stated Individual #188 should have a high sensitivity Fetal Occult Blood Test (FOBT) rather than a colonoscopy because the risk of perforation exceeded the benefit. The CLDP did not include this information.
- A CLDP support called for staff to monitor Individual #188's seizure activity, but did not call for staff training or knowledge about his individual needs. Per the IRRF, he was at high risk for seizure activity. Per the psychiatric assessment, Individual #188 had complex partial seizures with some pseudo-seizures that occurred when he became upset. The seizures primarily consisted of paroxysms of running, screaming and confusion with less frequent major motor with complete loss of consciousness. In addition, a consultant neurologist had recommended a Vagus Nerve Stimulator (VNS), but consent by the mother could not be obtained.

c. What was important to the individual: The CLDP section addressing outcomes important to the individual and related personal goals was left blank. His ISP vision statement and personal goals focused on his bicycle, shaving, bowling, and other outings. The CLDP narrative stated he no longer rode or showed interest in his bike, but it was not clear if this had been due to the unsteadiness and falls the IDT attributed to a medication issue (that had been resolved). The CLDP did not reference bowling as a preference and the only other support for outings called for him to have at least one opportunity quarterly to attend a movie of his choice at the theater.

d. Need/desire for employment, and/or other meaningful day activities in integrated community settings: The IDT determined that Individual #188 no longer wished to work, based on his increasing refusals to participate in bagging towels at his SSLC day program. The CLDP narrative indicated he would be attending a specific day habilitation program operated by the provider that provided socialization skills activities as well as employment support if Individual #188 were to express an interest in the future. The IDT did not include any specific support about day habilitation attendance or any meaningful day activities in integrated community settings. The only support that addressed community participation at all was having the opportunity to go to a movie at least once quarterly.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success: It was positive to see the CLDP included a support for positive reinforcement and motivating components for Individual #188. A communication strategies support included avoiding negative words known to bother Individual #188 and how to replace those with responses to which he reacted more favorably, as well as using his interests to build motivation to communicate. It would have been good to also see some other strategies identified in assessments integrated into supports. For example, the vocational assessment stated he responded well when praised and encouraged at short intervals, offered a short break after training trials, and greeted positively when he entered a room. The behavioral health assessment also noted he liked to hear accolades from staff when he did something that should garner him approval. The IDTs may need assistance from transition staff to consider how such supports could be quantified, through a mix of interviews, observations, and documentation as appropriate to the nature of the support. For instance, both staff interviews and observations could be used to assess whether provider staff knew Individual #188 liked to be greeted when entering a room and whether they did so when observed in the home and day program.

f. Teaching, maintenance, participation, and acquisition of specific skills: The IDT developed a support for the provider to

implement a formal training program for shaving. In his ISP, Individual #188 had an action plan to learn to make purchases in the community and to verbalize his interest in going on outings. Both of these skill acquisition plans (SAPs) would have been appropriate for continuation in the community. Also, the CLDP did not include any support related to Individual #188's need for staff prompting for toileting or follow-up to a discussion with the provider about developing a toileting schedule since he experienced both urinary and bowel incontinence at times.

g. All recommendations from assessments are included, or if not, there is a rationale provided: The Center had a process for reviewing CLDP assessments, documenting discussion, and making final recommendations. This was a good beginning, but this CLDP did not ensure that all final recommendations were included in supports. There were recommendations that were either not addressed or did not have an adequate rationale provided for not being included. Sometimes clinicians embedded recommendations in their assessment narratives, but did not carry them through to the recommendations section. This resulted in important recommendations not being carried over to the CLDP discussion and or included in CLDP supports. Some examples were described above, such as the lack of a support for the need to have FOBT instead of a colonoscopy. Other examples included:

- The narrative summaries of the nursing and nutrition assessments included detailed information about Individual #188's dietary needs, including, for example, that he received a 1500-calorie, low sodium, chopped; 2 T bran at all meals in l/2c applesauce. If he were to consume less than 50% of his meal, he was to receive a supplement. The nutrition final recommendations included that he should continue to receive his current diet. The CLDP supports did not include any specific support about his dietary needs, other than two supports calling for being offered a healthy diet and availability of healthy snacks.
- The nursing assessment indicated he should continue to have a quarterly AIMs and semi-annual MOSES. These were not included in the CLDP supports.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: Overall, post move monitoring was occurring as required and was done diligently. However, attention to the various details required for thorough post move monitoring is needed in order to meet the criteria for these indicators. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	188								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	0% 0/1	0/1								
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has	0% 0/1	0/1								

	been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.										
6	The PMM's assessment is correct based on the evidence.	0% 0/1	0/1								
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	0% 0/1	0/1								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	1/1								

Comments:

3. Post-move monitoring had been completed for the 7-Day and 45-Day post move monitoring periods. Both were completed at required intervals. Each of these post-move monitoring visits was within the required timeframe, included all locations where the individual lived or worked, were done in the proper format, and included comments regarding the provision of most support. While the comments were helpful to understanding how the transition was progressing, some improvements to the process were needed. For example:

- There was a missing support from the CLDP calling for Individual #188's bowel movements to be documented in a daily stool log, due to his history of chronic constipation. The PMM Checklists did not include this important health care support and there was no justification provided for deleting it. Per interview, this was an inadvertent deletion and the support should have been included in the Checklist and assessed for presence or absence.
- Some comments did not address the full intent or scope of a support. For example, a support indicated the provider would ensure that Individual #188 had ready access to direct care staff to help him become familiar with his new home and neighborhood. The PMM noted the availability of staff and assistance with personal care, but did not address his familiarity with his new neighborhood.

4. In many cases, the PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports, but there were issues that compromised reliability and validity. For example, it was not always possible to ascertain whether reliable and valid data were present, due in part to a lack of specificity and measurability of some supports as described in indicator 1. Other examples are described throughout this section.

5. Based on information the Post Move Monitor collected, Individual #188 had not consistently received supports as listed and/or described in the CLDP. Examples included:

- At the time of the 7-Day PMM visit, provider staff had not been inserviced and were not knowledgeable of some important supports, including Individual #188's diet orders, allergy to NSAIDS, and that he needed verbal prompting to not wear the same clothes every day.
- At the time of the 45-Day PMM visit, the provider had not yet assisted Individual #188 to apply for Social Security benefits. The

support was originally due within two weeks of transition, but this was delayed because San Antonio SSLC staff did not provide the necessary documentation until 3/11/17. The 45-Day PMM visit occurred almost a month after the needed paperwork was provided, so it should have been completed by then, using the original two-week expectation as a benchmark.

- At the time of the 45-Day PMM visit, Individual #188's ears had not been checked for cerumen, a support that was due by 4/7/17.

6. Based on the supports defined in the CLDP, some scoring was not accurate based upon the available evidence. Examples included:
    - At the time of the 7-Day PMM visit, a support for ensuring Individual #188 received his medications as required was marked as in place. A comment dated 3/8/17 and 3/9/17 indicated the PMM checked Individual #188's medication at his home and all medication was locked away in a closet. The PMM also reported reviewing Individual #188's MARS, which was accurate and up to date. She further noted that staff reported Individual #188 took his medication with no hesitation and that he continued to take his medication with water. The PMM Checklist contained contradictory information under the Area of Concern/Unmet Need section. This section documented the PMM discovered a small medication measuring cup in Individual #188's bedroom sitting on top of his dresser with a white substance that had started to harden. While provider staff were not able to identify the substance, the PMM noted that Individual #188 took Mira Lax, which is a white substance. Staff were reminded they must watch Individual #188 take his medication, not just give it to him and let him walk away. Further, the PMM documented group home staff was not sure where medications were located in the home or what a MARS was and how to document. These issues called into question whether he was receiving his medication as needed and whether the MARS was indeed correct.
    - At the time of the 45-Day PMM visit, the PMM marked as not applicable at least two supports that should have documented as not present. These included:
        - The support for application for Social Security benefits had not been completed within two weeks of receiving the needed paperwork from San Antonio SSLC.
        - The support for having his ears checked for cerumen had not been completed by the required due date, even though Individual #188 had been to see the community physician by then. No justification was provided.
    - At the time of the 45-Day PMM visit, the PMM marked Additional Question 4a as not applicable. This question addresses whether behavioral incidents did not occur. It should have been marked as No, based on the information provided in Additional Question 4b, which stated staff reported one incident at the day habilitation program, during which Individual #188 became very upset and was cursing and flipping tables over. Staff believed he became upset when another client started screaming, yelling very loudly.

7-8. The PMM was generally diligent in both identifying and following-up on supports that were not being provided. The Monitoring Team was impressed with the assertive action and follow-up taken by the PMM for supports not in place at the time of the 7-Day PMM visit, as described under indicator 5 above. The PMM phoned the provider case manager and staff upon discovering that provider staff had not been trained in key supports and requested an immediate meeting. She was able to verify these issues were corrected while onsite and returned the following day to observe that supports were being carried out as prescribed. Still, some needed follow-up did not occur in a timely manner for other supports. Examples at the time of the 45-Day PMM visit included:

- The provider had not yet assisted Individual #188 to apply for SSI. The PMM indicated only that the provider expressed they would be taking care of this, but no date was given and no follow-up plan was indicated.
- Individual #188's ears had not been checked for cerumen and no follow-up plan was indicated.

- There was a lack of information related to Individual #188's supports for neurological and pulmonary exams, given Individual #188's known medical conditions in these areas. Both were indicated to occur annually unless otherwise ordered by the community physician. The comments stated only that exams had not occurred and the community physician had not made a referral. No follow-up plan was indicated.
- After the behavioral incident at the day habilitation program, Individual #188's new psychiatrist requested a behavior support plan be started. The PMM did not document when this was to begin or indicate any follow-up plan.

In interview, transition staff indicated no post-move ISPA had been held to discuss any of these issues. The Monitoring Team recommended the Center consider the role of the IDT in post-move review and develop a consistent process they feel will ensure all appropriate eyes are on the status of supports, especially those that are not implemented as required. The PMM would benefit from input and feedback from the expertise of the IDT, rather than trying to make all decisions about whether additional follow-up is needed.

9-10. Post move monitoring was observed by the Monitoring Team for Individual #225. The post move monitoring was conducted by the transition specialist because the post move monitor had resigned her position and left the facility a week or so prior to the Monitoring Team's onsite week. Further, the transition specialist was not notified that she would be conducting post move monitoring until the day before. Even so, overall, she conducted post move monitoring thoroughly and the report accurately reflected what was observed by the Monitoring Team. Her interaction style during the home visit was pleasant and friendly, making the individual and her family at ease with the post move monitoring (and the presence of the Monitoring Team). Further, the report detailed some of the follow-up and additional documentation review conducted by the transition specialist in the days following the visit to the individual's home.

The individual lived with her family in a family care provider arrangement. This was the 9-month post move monitoring. Overall, she was doing very well. Since her transition home, there were many important positive outcomes: she had lost some weight (a major accomplishment given her Prader-Willi diagnosis), a psychotropic medication clozapine was discontinued because of her increased psychiatric stability, and there was no longer a need for the C-PAP device while sleeping. Furthermore, there was a reduction in problem behavior occurrences (though see below), she was readily going to day program each day, she was happy, and her mother was happy, too.

In the report, the transition specialist described the status of each of the 62 supports and wrote what she examined. The column in the report labeled evidence reviewed described what was probably in the CLDP, not what she reviewed. What she reviewed was in her note for each support. These notes should describe each of the three prongs of post move monitoring, that is, what is learned from interview, observation, and documentation. These three were not referenced in the note for each support. Given this was a family home care arrangement, and given it was the nine month review, some indication of the expectation for documentation by the family should be explained in the post move monitoring report. Often, after the first 90 days, documentation expectations may change, especially in a family care arrangement.

Overall, the report was very good, but in addition to the details regarding the three prongs of post move monitoring, some information in the report was missing or incorrect. For example, a note regarding the discontinuation of the clozapine (due to Individual #225's improved psychiatric status) would be good to have included in the note for item 32. Also, a very serious behavioral incident occurred

in the community just two weeks prior to this home visit. It was so serious that police were involved and it could have (but fortunately did not) resulted in hospitalization, arrest, or even a return to the facility. It was not reported to the facility, and although not required after the first 90 days (as per interpretive guidelines for scoring this indicator), given the severity, it would have been helpful to the facility, IDT, and LIDDA, especially if a second incident had occurred. The additional questions at the end of the report should have some notes/comments from the transition specialist. Also, item 1 said no changes to medications, but there had been a number of changes, and item 4a said there were no behavioral incidents, but there were.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.											
Summary: No negative events occurred for this individual. This was very good to see. This important indicator will continue to be under active monitoring.			Individuals:								
#	Indicator	Overall Score	188								
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% 1/1	1/1								
Comments: 11. Individual #188 had not experienced negative Potentially Disrupted Community Transition (PDCT) event.											

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 made progress on some of these indicators, though as detailed below, improvements in quality and detail are needed. The completion of all relevant assessments, as well as the quality of transition assessments, are areas of focus for the Center. Although Center staff provided training to community provider staff, the CLDPs did not define training well. Indicators 13 and 18 scored at 100% for this review and the last review. With sustained high performance, they might be moved to the category of requiring less oversight after the next review. The indicators of this outcome will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	188								
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a	0% 0/1	0/1								

	community setting.										
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% 1/1	1/1								
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/1	0/1								
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/1	0/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	100% 1/1	1/1								
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/1	0/1								
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	100% 1/1	1/1								
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/1	0/1								

Comments:

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

- Assessments updated with 45 Days of transition: The Center did not review or update the Integrated Risk Rating Form (IRRF), but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process. It was positive that the RNCM had completed a review of the Integrated Health Care Plan (IHCP.) Overall, meeting the timeliness criterion was impacted by a delay in the projected transition date. Most disciplines completed their assessments in January 2017, in anticipation of a 1/31/17 transition date. Since he did not transition until 3/7/17, most of these assessments were then not within 45 days. When such a delay occurs, the IDT should confirm the earlier assessments still reflect an individual's current status. As an example, the

nutrition assessment was completed on 1/4/17 and indicated an ISPA had been held for unexplained weight loss. At that time, the IDT deferred any action because they believed this was medication related due to suspected over-sedation. Additional weight data to confirm the accuracy of this IDT decision should have been available by the time the CLDP was held and should have been updated. It was also noted the communication assessment was not timely. It was dated 6/27/16 and was an update from a comprehensive assessment dated 7/3/13.

- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments that were not available or updated had a negative impact on the scoring of this indicator for both individuals. In addition, the medical assessment did not provide a complete assessment of relevant facts, such as his current laboratory results. The vocational, psychiatric, and behavioral assessments, on the other hand, provided a good summary of relevant facts. The Functional Skills Assessment (FSA) provided for review did not include a narrative summary,
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not consistently meet criterion for this indicator. Again, missing assessments factored into this determination. The medical assessment also did not provide a comprehensive set of recommendations. Recommendations were limited to medical follow-up every six months to one year, that he was not a candidate for either hospice or a change in DNR status as he had been clinically stable, that he may participate in swimming activities and has no significant health risks for restraints, and that he would need pretreatment sedation for medical procedures or imaging studies. There were no recommendations regarding his specific medical conditions. In addition, the FSA did not provide a summary with recommendations.
- Assessments specifically address/focus on the new community home and day/work settings: The medical, nursing, behavioral and OT/PT assessments did not address/focus on the new community home and day/work settings. The FSA did not provide a summary with recommendations.

13. The CLDP met criterion for this indicator. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) there was documentation to show IDT members actively participated in the transition planning process, 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting..

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: Although the CLDPs did not include specific staff training supports, pre-move training was provided as described in the Transition Log. The Monitoring Team requested and reviewed the training documentation, including the training and testing materials. The pre-move training did not include any documentation of staff knowledge or competence.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The CLDP should provide a specific statement documenting its consideration of the need for any such collaboration, and develop a corresponding support as appropriate. This CLDP developed supports calling for the San Antonio SSLC BCBA and psychiatrist to be available as needed for consultation throughout the first year and provided a phone number. This addressed a general, as needed, offer of collaboration, but did not address whether there were any specific needs for collaboration prior to, or after, transition. This was concerning because the psychiatric summary stated it was very important to make sure the community psychiatrists and PCP were

aware of, and read, the psychiatric summary, so they wouldn't make random medication changes with negative results (an all too frequency occurrence). This indicated a specific need for collaboration the IDT should have discussed.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results. The IDT documented the identification of a gravel pathway in front of the house that needed to be modified to smooth concrete. This was positive and the CLDP met criterion for this indicator. In the future, the Center should specifically state what needed setting assessments were considered.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the facility, facility direct support staff spending time with the individual in the community, and facility and provider direct support staff meeting to discuss the individual's needs. The CLDP should include a specific statement of the IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results

18. LIDDA participation: This indicator met criterion. In addition to assisting in the identification of provider resources, the LIDDA Service Coordinator participated in the CLDP.

19. The Pre-Move Site Reviews (PMSR) was completed in a timely manner and indicated all supports were not yet in place. A support called for the APC to give the provider a copy of Individual #188's 90-I and any documentation required to assist in his application for Social Security. This had not been accomplished at the time of the PMSR or on the day of move. The 7-Day PMM Checklist documented this support was completed after Individual #188 had moved. In addition, due to the lack of supports for staff training, knowledge and competence, the PMSR failed to document that provider staff had knowledge of important health and safety needs that should have been clearly in place at the time of transition.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: Criteria were met for this indicator for this individual. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	188								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 1/1	1/1								

Comments:
20. Individual #188 was referred on 7/13/16 and transitioned on 3/7/17. The Transition Log provided substantial detail about the transition process, which was helpful. It did not clarify the reason for delay of the CLDP, which was originally scheduled for 1/31/17, but not held until 2/21/17. In interview, transition staff clarified this delay was due to the provider completing the paving of the path to the home. This was an appropriate and prudent rationale.

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