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.

In addition, since the last review, San Antonio SSLC hosted the individuals from the Corpus Christi SSLC during a multiple-day evacuation due to Hurricane Harvey. The Monitoring Team heard a number of stories from staff and administrators positively describing the efforts of staff from both Centers to support individuals during that difficult period.

Also, San Antonio SSLC maintained stability in the majority of its management and clinical leadership staff. This sets the occasion for continued to progress to occur. The Monitoring Teams look forward to seeing considerable progress at the time of the next onsite review.

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, 16 of these indicators were in the category of requiring less oversight. During this review two other indicators had sustained high performance scores and will be moved to the category of requiring less oversight. These were in restraint management. On the other hand, one indicator in abuse/neglect incident management, showed decrease in performance such that it was returned to active monitoring.

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

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

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

<u>Restraint</u>
The Center presented a very clear set of graphs summarizing the overall usage of crisis intervention restraint at the Center. There was a strongly ascending trend over the past five months for crisis intervention restraints. The vast majority were crisis intervention physical restraints, however, crisis intervention chemical restraints also showed an ascending trend, though the numbers were lower than for crisis intervention physical restraint. Crisis intervention restraints for two individuals accounted for about half of all restraints. The average duration of a crisis intervention physical restraint was also increasing, averaging about six minutes per restraint (second highest in the state), also likely due to the same two individuals. Behavioral health services was addressing both, by updating PBSPs and working with psychiatry.

Even though there was an increasing usage of crisis intervention restraint, at least for two individuals, individuals who were restrained received that restraint in a safe manner and individuals were monitored during and after restraint to ensure safety. Overall documentation of implementation and team review was very good. The Center continued to do good work in managing

the use of protective mechanical restraint for self-injurious behavior (PMR-SIB), however, data needed to be collected to determine if usage was increasing or decreasing/fading.
Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing follow-up for abnormalities in vital signs; providing more detailed descriptions of individuals' mental status, including specific descriptions of the individual's behavior; and completing and documenting assessments to determine whether or not the individual has sustained an injury as a result of restraint. The lack of nursing assessments for medical restraint and PMR-SIB was of particular concern.

The restraint reduction committee was active and met each month under the leadership of the director of behavioral health services. Data were reviewed for the entire Center, as well as per home, time of day, etc.

Abuse, Neglect, and Incident Management
Background checks and duty to report activities were completed, and if behaviors that occurred during the incidents were ones that had occurred before, and there was prior review, trending, supports/plans in place (typically a PNMP or PBSP), and review of those supports/plans. This was good to see. In addition, the QA director reported that the Center continued its incident checklist system of review, and the unit directors reported that each month, they held a unit QA review at one of their morning meetings.

Investigation content was, for the most part, good. Staff knowledge of abuse and neglect reporting was good.

Under the leadership of the IMC, the Center took assertive actions when there were questions about aspects of DFPS investigations (e.g., absence of interview of an alleged perpetrator, appealing a finding).

There were several instances where timely reporting did not meet criteria and alleged perpetrators were not immediately re-assigned. To address this, at least from an incident management perspective, the UIR needs to be more descriptive in detailing the circumstances associated with reporting to determine if something should have been reported earlier than it was and if proper actions regarding alleged perpetrator re-assignment occurred or should have occurred.

There were problems with the way recommendations were written in the investigations. The Review Authority needs to be more proactive and more prescriptive rather than solely delegating to a unit director or other administrator.

Trend data were incomplete, therefore, everything that flows from this (data analysis, conclusions, corrective action planning) was also incomplete.

Other
Progress was noted with regard to the completion of clinically relevant DUEs.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: The usage of crisis intervention restraint at San Antonio SSLC showed an increasing trend, though much of it may have been due to one individual who was admitted in June 2017. The restraint reduction committee remained active. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	67% 8/12	This is a facility indicator.									
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	75% 9/12	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (April 2017 through December 2017) were reviewed. The behavioral health services department provided a set of graphs that presented the data in an easy to understand manner. The use of crisis intervention restraint showed an ascending trend over the nine-month period, especially during the most recent four or five months. The same trend was also seen for the usage of crisis intervention physical restraints because the vast majority of crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention physical restraint was also increasing. Over the nine-month period, it average about six minutes per restraint (second highest in the state) and at about 10 minutes during the past few months. The use of crisis intervention chemical restraints and crisis intervention mechanical restraints, however, remained low. The Center reported zero injuries to have occurred during restraint implementation, however, there were missing components in documentation by nursing regarding evaluation of the individuals after restraint occurred.

The number of individuals who had a crisis intervention restraint each month was decreasing and was showing a somewhat ascending trend towards the latter part of the nine-month period. One individual at San Antonio SSLC accounted for the majority of crisis intervention restraints and, moreover, a number of the restraints were lengthy and that contributed to a higher Center average. The Center might find it valuable to also analyze/trend the data for these two individuals as part of their overall restraint review process (as has been done at some of the other Centers). For instance, at the same time, the Center reported that three individuals no longer needed crisis intervention restraint (though a crisis intervention restraint occurred for one of them Individual #138, during the onsite review week).

Two individuals had protective mechanical restraint for self-injurious behavior (PMR-SIB). This was a decrease from three/four at the time of the last review and was good to see. There were no data regarding the in/out amount of time for both individuals, but there should be in the future. In addition, there continued to be inconsistencies regarding the classification (and required monitoring) for some individuals' usage of medical restraint versus protective devices (state policy8 #55). This was also noted in the last report. The Center should attend to this and ensure that all protective devices are properly categorized (e.g., Individual #30, post-hospitalization

abdominal restraint).

There were few occurrences of non-chemical restraints for medical or dental procedures and few (one to two per month) occurrences of the use of pretreatment sedation. The frequency of TIVA for dental procedures remained stable at about nine individuals per month.

Thus, facility data showed low/zero usage and/or decreases in eight of these 12 facility-wide measures (use of crisis intervention chemical and mechanical restraint, restraint-related injuries, use of PMR-SIB, use of pretreatment sedation for medical and dental, use of TIVA for dental procedures, and use of non-chemical restraints for medical and dental procedures.

The restraint reduction committee was active and met each month under the leadership of the director of behavioral health services. Data were reviewed for the entire Center, as well as per home, time of day, etc.

2. Four of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, physical, medical, and PMR-SIB restraints were reviewed for three additional individuals. Of these seven individuals, five received crisis intervention physical restraints (Individual #125, Individual #191, Individual #207, Individual #184, Individual #95) one received crisis intervention chemical restraint (Individual #184), and two received medical or PMR-SIB restraints (Individual #30). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for two of the seven (Individual #125, Individual #207, Individual #95, Individual #30). The other individuals reviewed by the behavioral health Monitoring Team had no occurrences of crisis intervention restraint and were scored positively for this indicator. There were no data for Individual #141's amount of time in/out of PMR-SIB.

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: Indicators 5 and 6 showed sustained high performance across this and the three previous reviews and, therefore, both 5 and 6 will be moved to the category of requiring less oversight. Indicator 9 also showed some improvement, scoring higher than 0% for the first time. With sustained high performance indicator 11 might be moved to the category of requiring less oversight after the next review. Lastly, some modifications about the way IRIS displays information regarding the administration of crisis intervention chemical restraint are needed for that indicator to move to the category of requiring less oversight. Indicators 9, 10, and 11 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	125	191	207	184	95	30	141		
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	100%	1/1	1/1	1/1	2/2	1/1	1/1	1/1		

	him/herself or others.	8/8									
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	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.	33% 1/3	Not rated	0/1	Not rated	1/1	Not rated	Not rated	0/1		
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	88% 7/8	1/1	1/1	1/1	1/2	1/1	1/1	1/1		
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		

Comments:

The Monitoring Team chose to review eight restraint incidents that occurred for seven different individuals (Individual #125, Individual #191, Individual #207, Individual #184, Individual #95, Individual #30, Individual #141). Of these, five were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and two were medical or PMR-SIB. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

9. When criterion for indicator 2 is met, this indicator is not scored. That was the case for four of the seven individuals. For the other three, all of the sub-indicators were met for one individual (Individual #184), and many of the sub-indicators were met for Individual #191 (except for reliable PBSP data and implementation of PBSP.

For Individual #141, it appeared that there were one or two self-injurious incidents in the past six months or so (but there were some questions about the reliability of the data and whether a 1 was entered incorrectly as a 10). If indeed self-injurious behavior was occurring this, the IDT should have considered a fading program for the helmet. Further, if, as suggested in some of his records, self-injurious behavior was related to communication, he should have (but did not) a communication plan in place.

10. For the one crisis intervention chemical restraint, there was conflicting data/information regarding the administration time. This was perhaps a function of the IRIS system that displays as "time performed" a time that was more likely the time of data entry into the IRIS system.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary:			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: With sustained high performance, both indicators might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	191	207	184	95	30	141		
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	83% 5/6	1/1	0/1	1/1	2/2	1/1	N/A	N/A		
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.	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	1/1		
Comments: 13. For Individual #191 10/12/17, the one-minute restraint began at 4:02 pm and the restraint monitor arrived at 4:57 pm. 14. Proper protocols were implemented and documented for both individuals regarding the content of this indicator.											

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: providing follow-up for abnormalities in vital signs; providing more detailed descriptions of individuals' mental status, including specific descriptions of the individual's behavior; and completing and documenting assessments to determine whether or not the individual has sustained an injury as a result of restraint. The lack of nursing assessments for medical restraint and PMR-SIB was of particular concern. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	191	207	184	95	30	141		
a.	If the individual is restrained, nursing assessments (physical	13%	0/1	0/1	0/1	0/2	1/1	0/1	0/1		

	assessments) are performed.	1/8									
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	13% 1/8	0/1	0/1	0/1	0/2	1/1	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% 0/8	0/1	0/1	0/1	0/2	0/1	0/1	0/1		

Comments: The crisis intervention restraints reviewed included those for: Individual #125 on 7/24/17 at 4:20 p.m.; Individual #191 on 10/12/17 at 4:02 p.m.; Individual #207 on 6/6/17 at 6:00 p.m.; Individual #184 on 9/10/17 at 5:05 p.m., and 11/15/17 at 4:42 p.m. (chemical); Individual #95 on 10/26/17 at 12:57 p.m.; Individual #30 from 8/19/17 to 8/25/17 (medical restraints – wristlets); and Individual #141 from 12/2/17 to 12/8/17 (PMR-SIB – helmet).

a. through c. The following provide examples of concerns noted:

- Individual #125's mental status was described as "no change from baseline." In addition, The Nurse stated no injuries, but a corresponding IView entry for an assessment of skin was not found. Nursing staff did not provide or document follow-up for the low temperature and high diastolic blood pressure.
- Individual #191 refused to allow the nurse to take his vital signs, but the nurse did not document respirations, which do not require the individual's cooperation. In addition, the individual's mental status was described as "no change from baseline." The nurse noted "no visible injuries," but a corresponding IView entry for an assessment of skin was not found.
- Based on the documentation provided for Individual #184's restraint on 9/10/17, the Monitoring Team could not determine the time of arrival of the nurse. The individual refused to allow the nurse to take his vital signs, but the nurse did not document respirations, which do not require the individual's cooperation. However, the nurse concluded that the individual had no signs and symptoms of respiratory distress. The nurse did not provide a specific description of the individual's mental status. Although an ISPA indicated that a nurse completed an assessment and found no injuries, no documentation of such an assessment was found.
- After Individual #184's chemical restraint on 11/15/17, nursing staff did not complete follow-up at the frequency necessary to address high and low values of vital signs. The individual's mental status was described as "no change from baseline," or "alert," which did not provide the necessary specifics.
- It was positive that the nurse completed the necessary physical assessments of Individual #95 after her restraint on 10/26/17. However, at 1:57 p.m., the nurse noted the individual's right and left pupil reactions were sluggish, but did not conduct follow-up.
- For Individual #30's wristlets, the majority of nursing entries in IPNs and IView did not specifically document assessment of the wrist restraint, such as skin color, whether the skin was intact, radial pulse with rate, and circulation (e.g. capillary refill). Also of concern, the individual's IHCP did not include interventions regarding this ongoing restraint.
- For Individual #141, records indicated that a protective restraint in the form of a helmet was used to prevent the individual from hitting his face and head. The documents provided were hand-written forms, and no nursing information was included for the seven days reviewed. The Center did not submit a physician order for the helmet. No nursing IPNs or IView documentation specific to the helmet were submitted. The IHCP did not have any entries related to the helmet/restraint interventions.

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:													

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:													

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: This outcome was applied to one individual's crisis intervention chemical restraint. Documentation, attention, and follow-up occurred. These indicators will remain in active monitoring.			Individuals:										
#	Indicator	Overall Score	184										
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.	100% 1/1	1/1										
Comments: 47 and 49. These indicators applied to one individual, Individual #184. Psychiatry staff reviewed the chemical restraint episode in a timely manner. In addition, Individual #184was seen in psychiatry clinic the day after the event. This was good to see. 48. The medications utilized during the event were a combination of Haldol, Ativan, and Benadryl. This combination of medications can													

cause significant medication side effects. It would be good for psychiatry to determine if a single agent medication would be effective in order to reduce the risk of medication interaction side effects.

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 continued to regularly review trends and supports/plans were in place to have reduced the likelihood of the incidents occurring. All four sub-indicators met criteria showing progress on this indicator, this time to 100% of the incidents reviewed for this monitoring visit. This demonstrates the continued evolution of the incident management department and program at the Center. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	125	290	191	100	354	207	222	327	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 10/10	2/2	1/1	2/2	1/1	1/1	1/1	1/1	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 (three confirmed, three unconfirmed, one streamlined and unfounded). The other three were for facility investigations of a fire and serious injuries (fracture, laceration). 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 #125, UIR 18-075, DFPS 45665647, unconfirmed allegation of neglect, abbreviated investigation, 10/18/17
- Individual #125, UIR 18-011, trailer fire, 10/30/17
- Individual #290, Individual #184, and others, UIR 18-056, DFPS 45601100 merged with 45605109, inconclusive and unconfirmed allegations of neglect, abbreviated investigation, 10/7/17
- Individual #191, UIR 17-251, DFPS 45330598, confirmed allegations of physical abuse and neglect, OIG involvement, 6/15/17
- Individual #191, UIR 17-072/327, DFPS 45371510, sexual incident and confirmed allegation of neglect, 7/13/17
- Individual #100, UIR 18-012, witnessed injury, laceration, 11/21/17
- Individual #354, UIR 17-364, DFPS 45418616, inconclusive allegation of physical abuse, OIG involvement, 8/13/17
- Individual #207, UIR 18-094, DFPS 45782108, unconfirmed allegation of neglect, abbreviated investigation, 11/7/17
- Individual #222, UIR 18-142, DFPS 45966680, unfounded allegation of verbal abuse, streamlined investigation, 12/11/17
- Individual #327, UIR 18-022, discovered injury, fracture, jaw, 9/16/17

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.

All aspects (sub-indicators a, b, c, and d) met criteria for those investigations for which those indicators were applicable. That is, sufficient background and duty to report activities were completed, and the behaviors that occurred during the incidents were ones that had occurred before, and there was prior review, trending, supports/plans in place (typically a PNMP or PBSP), and review of those supports/plans. The QA director reported that the Center continued to have non-allegation incidents reviewed by various disciplines regarding their support system in order, primarily, to improve supports in the future (called incident checklists). The unit directors also reported that each month, they held a unit QA review at one of their morning meetings. These were not scheduled the week of the onsite review.

One streamlined investigation was included in this set of investigations. All criteria in this section of the report, except for indicator 16, were met. San Antonio SSLC was able to demonstrate that SSLC protocols were being followed for individuals who were designated for streamlined investigations (e.g., Individual #222), however, could not show evidence that DFPS completed one of its requirements, that is, to do a quarterly determination of whether an individual should or should not remain on the list. After submission of the draft version of this report, DFPS sent the minutes from their quarterly meeting with the San Antonio SSLC. The minutes detailed a number of relevant topics discussed by the group, including the current status of Individual #222. This was good to see. However, even though there was good discussion and there was documentation of an extremely high number of unfounded allegations made by the individual, there was no explicit statement about the individual meeting criteria as per the DFPS 2390 streamlined caller protocol.

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

Summary: To repeat from the last review, 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. In addition, deeper digging into the circumstances around reporting might shed some light on understanding why an incident was not reported correctly. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	125	290	191	100	354	207	222	327	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	60% 6/10	2/2	0/1	1/2	1/1	0/1	0/1	1/1	1/1	

Comments:

2. The Monitoring Team rated six of the investigations as being reported correctly. The other four 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.

- For Individual #290 UIR 18-056, the reporter was known. The incident was reported at 11:17 pm, but was reported to the Center by the State's ICF regulatory department. That is, given the circumstances of the incident, it is likely that a staff member reported it, albeit incorrectly and late.
- For Individual #191 UIR 17-251, per DFPS, the incident occurred at 3:30 pm and was reported at 5:41 pm. According to the UIR, the reporter was unknown.
- For Individual #354 UIR 17-364, was not initially reported to OIG. DFPS should have (even though initial report was neglect) recognized that what happened during the incident (based on the injury) should have been investigated as physical abuse.
- For Individual #207 UIR 18-094, per the DFPS report, the incident occurred at 8:15 am and was reported to them at 10:26 am. There was no information in the UIR as to who the likely reporter was (i.e., an individual, a staff member).

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 due to the need for improvement in reporting (indicator 2).

Individuals:

#	Indicator	Overall Score	125	290	191	100	354	207	222	327	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 1/1	Not rated	Not rated	Not rated	1/1	Not rated	Not rated	Not rated	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:

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

Summary: A steady decline in performance is evident when looking at this score and the scores from the previous three reviews. The UIR needs to delve deeper and describe in more detail the circumstances around any protection that is not put in place immediately. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall	125	290	191	100	354	207	222	327	

		Score									
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	60% 6/10	2/2	0/1	0/2	1/1	0/1	1/1	1/1	1/1	

Comments:

6. Four incidents did not meet criteria with this indicator:
   - For Individual #290 UIR 18-056, the UIR two alleged perpetrators were reassigned immediately, but a third alleged perpetrator was not reassigned until six days later. There was no explanation for this in the UIR or review documentation.
   - For Individual #191 UIR 17-251, because this was reported late, the alleged perpetrators were not immediately reassigned.
   - For Individual #191 UIR 17-072/327, the incident occurred on 7/13/17 and reported to DFPS with two named alleged perpetrators. Per the UIR, one alleged perpetrator was placed on no client contact on 8/7/17 and the other on 8/10/17. There wasn't anything in the UIR that explained the circumstances associated with this.
   - For Individual #354 UIR 17-364, this injury likely happened sometime after the evening shower (approximately 8:30 pm) and when it was discovered at 7:30 am. No video was reviewed to see who might have been going in and out of the bedroom and could be a possible alleged perpetrator. (A staff member later confessed to OIG.)

Outcome 5– Staff cooperate with investigations.

Summary: For one investigation, staff cooperation was not fully evident for one investigation. Future occurrences need to be addressed and explained. This indicator, however, will remain in active monitoring.

Individuals:

#	Indicator	Overall Score									
7	Facility staff cooperated with the investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

7. For Individual #191 UIR 17-251, one staff member failed to show up for a scheduled interview. No information was provided regarding any action taken with that employee.

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

Summary: Aspects of two investigations were not done thoroughly. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	125	290	191	100	354	207	222	327	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
9	Relevant evidence was collected (e.g., physical, demonstrative,	90%	1/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	

	documentary, and testimonial), weighed, analyzed, and reconciled.	9/10									
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	80% 8/10	1/2	1/1	1/2	1/1	1/1	1/1	1/1	1/1	

Comments:
9-10. For Individual #125 UIR 18-075, the alleged perpetrator was not interviewed and there was no comment as to why. The incident happened in the kitchen, but there was no video review. Furthermore, the investigation concluded that staff intervened, but no evidence was provided, such as the name of the staff and interview notes. Therefore, not all relevant evidence was collected, weighed, analyzed, and reconciled.

For Individual #191 UIR 17-251, DFPS' original conclusion was unconfirmed physical abuse, confirmed neglect, and unconfirmed neglect. The Center appealed, and provided comments on their review of video evidence. DFPS revised its report and findings to confirmed physical abuse and confirmed neglect. This suggested the initial video review by DFPS was not thorough, or if thorough, did not reach an appropriate conclusion. It was good to see San Antonio SSLC thoughtfully utilizing the findings appeal process.

Outcome 7– Investigations are conducted and reviewed as required.

Summary:

Individuals:

#	Indicator	Overall Score	125	290	191	100	354	207	222	327	
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	2/2	0/1	1/2	1/1	1/1	1/1	1/1	0/1	
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	60% 6/10	1/2	0/1	0/2	1/1	1/1	1/1	1/1	1/1	

Comments:
12. Three investigations were not completed within 10 calendars (or had proper extensions completed):
- For Individual #290 UIR 18-054, the incident occurred on 10/7/17 and was completed on 10/27/17. The Center did not submit any extensions of other paperwork.
- For Individual #191 UIR 17-072/327, the extension request stated that a rationale that new witnesses were identified. However, given that the first staff interview was not until day 12, the investigation could not be completed in 10 days.
- For Individual #327 UIR 18-022, the incident was reported on 9/16/17 and was completed on 10/26/17. No extensions were

provided.

13. Supervisory review did not detect the missing or problematic aspects of four 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: There was an error in documentation regarding serious injury audits for four individuals (50%) as detailed in the comment below. This indicator (14) will remain in the category of requiring less oversight, but this must be corrected in order for that to remain the case.

#	Indicator	Overall Score	Individuals:								
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:

14. Documentation of serious injury audits contained a confusing and conflicting entry, that is, for four of the eight individuals (50%), the documents said that "yes" all injuries were documented and reported and it also said "no" to all serious injuries were documented and reported. There seems to be a misunderstanding on how to record data on the review sheet after completing the audit.

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

Summary: Investigations did not contain recommendations; instead they included a standard statement that concerns would be addressed by the unit director (or other administrator). This does not meet criteria and, therefore, none of the investigations met criterion. As a result, indicator 16 will be returned to active monitoring. The other two indicators scored somewhat lower than at the last review, too, in part due to the problems with recommendations as described below for indicator 16. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals:								
			125	290	191	100	354	207	222	327	

16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. But due to problems/absence of correctly written recommendations, this indicator will be returned to active monitoring.										
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	50% 1/2	N/A	1/1	0/1	N/A	N/A	N/A	N/A	N/A		
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	86% 6/7	1/2	1/1	1/1	1/1	1/1	1/1	N/A	N/A		

Comments:

16. The review document generated by the Review Authority at San Antonio SSLC always said, "this concern will be addressed by the unit director" (though sometimes it was a different administrator or manager). Rather than this standard statement that does not contain any information, the Review Authority should either direct/specify specific corrective action, or receive something from the named administrator or manager explaining what the planned corrective action is. The Review Authority should then review this plan and either accept it or basically say "that's not enough." In addition, the recommendations coming from the Review Authority did not typically address specific employee corrective or disciplinary action.

The Review Authority needs to be more proactive and more prescriptive. It is not sufficient to just delegate to a unit director or other administrator. At some of the other Centers, the relevant administrator (again, typically the unit director) sits in with the review authority and explains what they intend to do. This typically generates some discussion and modification of the originally planned actions, with the final set of planned actions recorded in the minutes of the review authority.

17. For Individual #191 17-251, there was nothing in the UIR regarding actions taken with the employees confirmed (though the Monitoring Team learned that the employment of five was terminated) or with the employee who did not show up for interview. Further, the UIR included two recommendations related to additional staff training, but no documentation as to whether this occurred.

There were three cases in which one or more staff were confirmed for physical abuse category 2. In all cases, employment was not maintained for any staff member who was confirmed for physical abuse category 2.

18. For Individual #125 UIR 18-011, the Center did not respond with a sense of urgency to the risk identified regarding needing to obtain fire extinguishers in vehicles. That is, vehicles probably should have been taken out of service until there was proof they had all required safety equipment.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. Trend data, analysis, and actions were not at criteria. These indicators will remain in active monitoring.			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. Some, but not all, data sets were being collected. Information in the QAQI Council report had more analysis and discussion than what was in the trend report. Action plans were general and tied primarily to the indicators reviewed by the Monitoring Team, rather than also (and more importantly) identifying and addressing underlying, and perhaps systemic, problems. The improvement plans did not include sections, such as problem statement, a set of action steps designed to correct the problem, a description of measurement of progress (presumably the same data points as in the problem statement), reporting on action step progress/completion, and data to confirm progress.											

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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	0/1	N/A	0/1	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. 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/general anesthesia need to be expanded and improved. For example, the Center's policy on the criteria for the use of TIVA were not consistent with the requirements included in the dental audit tool. In addition, the Center provided a policy entitled General Anesthesia (TIVA) - Medical Clearance. It addressed some aspects of perioperative evaluations, but was incomplete. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved											

with TIVA/general anesthesia, 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 the procedures and assessments completed, and post-operative vital sign flow sheets were completed according to the requirements of the policy.

b. Based on documentation the Center provided, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for dental services.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: a. Based on documentation the Center provided, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for medical procedures.											

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: Monitoring of this outcome and its indicators is put on hold while the State develops instructions, guidelines, and protocols for meeting criteria with this outcome and its indicators.			Individuals:								
#	Indicator	Overall Score									
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.										
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.										
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.										

4	Action plans were implemented.										
5	If implemented, progress was monitored.										
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.										
Comments:											

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 remain in active oversight.			Individuals:								
#	Indicator	Overall Score	253	54							
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% 2/2	1/1	1/1							
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/2	0/1	0/1							
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/2	0/1	0/1							
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/2	0/1	0/1							
e.	Recommendations are followed through to closure.	0% 0/2	0/1	0/1							

Comments: a. Since the last review, four individuals died. The Monitoring Team reviewed two deaths. At the time of the Monitoring Team's review, the Center's review and follow-up activities for Individual #243 and Individual #227 were not complete. Causes of death were listed as:

- On 5/25/17, Individual #253 died at the age of 61 with causes of death listed as "tracheostomy," and respiratory insufficiency;
- On 6/10/17, Individual #54 died at the age of 60 with causes of death listed as septic shock, pneumonia, and acute kidney failure due to acute tubular necrosis;
- On 1/11/18, Individual #243 died at the age of 56 with causes of death listed as aspiration pneumonia, and cerebral palsy; and
- On 1/18/18, Individual #227 died at the age of 72 with causes of death pending.

b. through d. Evidence was not submitted to show the Center conducted thorough reviews of medical and/or nursing care, or an analysis of medical/nursing reviews to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. The following provide some examples of concerns:

- For Individual #253, the mortality review committee developed a recommendation that the Pharmacy Department should assess high risk drugs, including amiodarone. This apparently was not done for this individual. While the Pharmacy Department should be involved, this issue pointed to a gap in medical care, but the committee did not develop a recommendation(s) to address changes to the PCPs' practices and/or medical policy.
- In reviewing Individual #253's death, the committee made a recommendation to check all automated external defibrillators (AEDs) on campus. The recommendation read: "All AEDs on campus should check [sic] with the manufacturer on the quality check of each machine. Recommend the nursing dept. contact the manufacturer with evidence submitted to the QA dept." In the documents the Center submitted, what followed were refrigerator checks, and a one-line entry, dated 11/6/17, stating: "Replacement of current AEDs - Pending approval." The Center submitted no further evidence of follow-up. Moreover, if the Center did not currently have a procedure related AED maintenance included in its comprehensive Emergency Response System (ERS) procedure, this is cause for concern and the entire ERS should be evaluated.
- With regard to Individual #54's death, the external medical reviewer provided an UpToDate article on percutaneous tube (PEG-tube) care. The deficiency that this was intended to address was not clear. In addition, based on the follow-up information the Center provided, it appeared staff were depending on the development of procedures that State Office was developing. It was unclear why Center staff had not defined a plan of care and established operational procedures for caring for individuals with enteral tubes.
- For Individual #54, the Quality Assurance/Quality Improvement (QA/QI) Nursing Death Review identified 10 items that required follow-up. Although the Administrative Death Review addressed a couple of these through recommendations, the majority were not addressed. Some of the issues that should have been addressed related to: 1) evidence revealed Integrated Progress Notes (IPNs) did not document nursing assessments related to increased heart rate and respirations (i.e., possible pain, post suctioning, during /post enteral nutrition, etc.); 2) evidence showed that blood pressures were not re-taken when a significant change was noted; and 3) nurses did not consistently document the condition of the individual's skin/stoma/ tracheostomy.
- Similarly, for Individual #253, the mortality review committee did not address the following issues identified through the QA/QI Nursing Death review: 1) it is of great concern that since the initiation of IRIS, documentation related to the notification of the PCP or on-call physician is problematic (e.g., change in lung sounds, such as crackles, vital signs, etc.); 2) ISP goals were not realistic or measurable, and generic interventions were included in action plans, such as "will be free from respiratory problems;" and 3) the IRRF lacked an analysis comparing the status from the previous year to the current year, which could have assisted in developing realistic goals and interventions.

e. The Center did not submit documentation to show that many of the recommendations for the two death reviews were implemented. For example, for Individual #253, the Center submitted documentation to show implementation of two of seven recommendations. The remaining had been "ongoing" since the due date of 6/25/17. Similarly, for Individual #54, the Center submitted documentation to show implementation of two of 13 recommendations. Based on the mortality log the Center submitted, the Monitoring Team could not

discern the status of the remaining 11 recommendations.

In its comments on the draft report, the State disputed a number of these findings. Many of the State's comments raised further concerns. For example, the State repeatedly stated: "The Monthly updated Mortality Log provided for review found within the Comment section as well as the Monthly Monitoring Random Audit Tool revealed the center continued to struggle in making significant improvement, so therefore recommendations could not be closed." It was unclear how the State expected that this information would change the Monitor's findings. In response to a number of the findings, the State indicated that nursing staff were working on recommendations that had not made their way into the formal mortality review recommendations. These indicators address the mortality review process, and the omission of important nursing recommendations showed significant flaws in the Center's mortality review process. In other instances, the State referenced documentation that the Monitoring Team previously reviewed, and found insufficient. After consideration of the State's comments, the Monitor chose not to make changes to the findings in the draft report.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	ADRs are reported immediately.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	100% 1/1					1/1				
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 1/1					1/1				
d.	Reportable ADRs are sent to MedWatch.	N/A					N/A				
Comments: a. through d. On 6/15/17, Individual #154 started taking Clozapine at 25 milligrams (mg) twice a day (BID). On 6/20/17, the dose was increased to 50 mg BID. On 6/22/17, significant sialorrhea was noted. On 6/23/17, it was reported that the individual was unable to take medications. Upon interview, the Speech Language Pathologist (SLP) reported that this was a new finding discovered on 6/20/17 or 6/21/17. The individual appeared unable to initiate food processing and food dribbled out of her mouth. On 6/23/17, Clozapine wad stopped and the symptoms resolved. On 6/26/17, Clozapine was restarted at a lower dose. The Pharmacy and Therapeutics Committee (P&T) discussion documented that sialorrhea was not observed, but dystonia was an adverse drug reaction.										

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: Progress was noted with regard to the completion of clinically relevant DUEs. 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.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/1
Comments: a. and b. Since the last review, San Antonio SSLC completed two DUEs, including: • In July 2017, a DUE on multivitamin/mineral supplementation, for which documentation was not submitted to show completion of the recommendations; and • On 12/1/17, a DUE on high-dose Vitamin D, for which follow-up was not yet due.		

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, 18 of these indicators were in the category of requiring less oversight. For this review, 11 other indicators were moved to this category, in ISPs, psychiatry, psychology/behavioral health, medical, dental, and skill acquisition plans. On the other hand, problems in performance in communication resulted in two indicators in that area being returned to active monitoring.

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

The IDT considered what assessments would be relevant to the development of an individualized ISP for all individuals. None, however, then arranged for and obtained all of these needed, relevant assessments.

IDTs met routinely when a serious incident occurred. This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure that recommendations were implemented. IDTs rarely revised goals when progress was not evident.

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.

For the individuals reviewed, annual medical assessments were generally timely. However, the quality of annual medical assessments still needed improvement. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, and plans of care for each active medical problem, when appropriate.

During past reviews and this review, newly-admitted individuals reviewed had timely dental exams and summaries, and individuals reviewed generally had timely annual dental summaries. As a result, two indicators will move to the category requiring less oversight. The Center should focus on ensuring that dental exams are completed within 90 days prior to individuals' ISP meetings. Although continued work was needed, good progress was noted with regard to 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, and the Physical and Nutritional Management Team (PNMT) discussed the results. The Center should focus on ensuring referral of all individuals that meet criteria for PNMT review, timely completion of the PNMT initial review, completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment and documentation of their involvement, and the quality of the PNMT comprehensive assessments.

A significant issue was that Center staff had not followed the current guidelines for considering when an OT/PT comprehensive should be repeated. For a number of individuals reviewed, the three-year mark had passed, and OTs/PTs had not completed a new comprehensive assessment, or justified why an update met the individual's needs. In addition, the comprehensive assessments and update reviewed needed improvement.

Based on the Monitoring Team's review of annual communication assessments and updates, the Center regressed with regard to the completion of timely annual communication assessments and updates in accordance with individuals' needs. The related indicator will return to active oversight. Of additional concern, the assessments that were completed were generally of poor quality.

All individuals had current and complete behavioral and functional assessments. Not all individuals had 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.

Individualized Support Plans

The Monitoring Teams attended two annual ISP meetings and two ISP preparation meetings, as well as some ISPA meetings, and a variety of other meetings during which individuals' services and supports were discussed. The Monitoring Teams visited with all individuals at their homes and in their day programs. Many positive and pleasant interactions were observed between direct support staff and individuals. Staff were engaged with individuals and were aware of their support needs. A number of new QIDPs had been hired. The Monitoring Team found them to be knowledgeable about the preferences, needs, and status of supports for the individuals on their caseload

There were improvements in the personal goals. A majority of the goals were individualized, aspirational, and based on preferences. None of the goals for health/wellness (IHCP), however, yet met criteria, but improvement efforts were underway, led by the QIDP Coordinator and Program Compliance Nurse (see indicator 12 in outcome 3 below). There continued to be a need for goals (and their action plans) to be implemented, and for accurate, reliable, and useful data to be collected.

Eleven goals had action plans that were likely to lead to the accomplishment of the goal. This was an improvement from the last review when five met this criterion (this was another recent focus of the QIDP Coordinator).

QIDPs reported that it was very difficult to implement goals that fell outside of the limited activities offered at the Center. The lack of opportunities leads to non-aspirational goals, such as continuing to work at the workshop, because IDTs do not want to get negative feedback about not implementing more aspirational goals when there are no resources to get those goals implemented. This is an interesting, but troubling, unintended contingency for QIDPs and IDTs that should be explored by the QIDPs, QIDP coordinator, and ADOP.

Most individuals took frequent trips into the community, but meaningful and substantial community integration was absent from almost all ISPs. Individuals were not given opportunities to utilize community resources that might support them to be more independent and integrated into the community. Work opportunities were limited to the few contracts available at the workshop.

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.

San Antonio SSLC now had two full-time psychiatrists, a psychiatric nurse, and psychiatric clinical support. This was the first time that they were fully staffed in several years. Various staff and managers reported that the psychiatrists were approachable, available, willing to be part of the team, and frequently in the homes and day program directly observing individuals and interacting with them and their staff.

There was some progress in the development of psychiatry-related goals, and the identification of psychiatric indicators. To move forward, accurate and reliable data on psychiatric indicators will be needed. Examples are for accurate sleep data, and manic symptoms (which of course need to be defined for the individual).

In behavioral health services, San Antonio SSLC did not have a data collection system that generated reliable, accurate, and valid. This should be a priority for the behavioral health services department. Its absence is a barrier to meeting criteria with a number of indicators in psychology/behavioral health.

All individuals had PBSPs that were current, and most, but not all, were complete in terms of content.

All individuals had goals/objectives for skill acquisition that were measurable, and were based upon assessments. About two-thirds of the SAPs were practical, functional, and meaningful and for which reliable data were being collected.

ISPs

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

Summary: Continued progress was seen, including 22 of the goals meeting criteria for individuality and 18 for measurability. For two individuals, five of the six goals met criteria for indicator 1. None of the goals for health/wellness (IHCP), however, yet met criteria, but improvement efforts were underway (see indicator 12 in outcome 3 below). There continued to be a need for these goals (and their action plans) to be implemented and for accurate, reliable, and useful data to be collected. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	191	114	100	207	154	142			
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	3/6	4/6	5/6	5/6	3/6	2/6			
2	The personal goals are measurable.	0% 0/6	3/6	4/6	2/6	5/6	3/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	1/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #114, Individual #207, Individual #191, Individual #100, Individual #154, Individual #142). The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the San Antonio SSLC campus.

1. The ISP relies on the development of personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. 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 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 areas. Therefore, none had a comprehensive set of goals that met criterion. For this set of individuals, however, the IDT had defined/chosen some personal goals that met criterion for being individualized, based on the individual's preferences and strengths. Overall, 22 of 36 personal goals met criterion for this indicator, this was an increase from 18 at the last review. Goals that met criterion were:

- Individual #114's goals for recreational/leisure, relationships, work/day, and greater independence.
- Individual #207's goals for recreation/leisure, relationships, work/day, greater independence, and living options.
- Individual #191's goals for recreation/leisure, greater independence, and living options.
- Individual #100's goals for recreation/leisure, relationships, greater independence, work/day, and living options.
- Individual #154's goals for recreation/leisure, relationships, and greater independence.
- Individual #142's recreation/leisure and greater independence.

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

Individual #100 had a full range of goals that were individualized and aspirational. His ISP meeting to develop goals for the upcoming year was observed by the Monitoring Team. While he had a full range of goals that were individualized and aspirational, few had been implemented. Rather than address barriers to implementation, the IDT discontinued his goals and chose new goals that were easier to implement, but provided little opportunity for learning new skills and becoming more independent. For example, his goal to work in the community at a nursery was revised to continue working on the contract that he had worked on in the past at the sheltered workshop. His relationship goal was revised from choosing an off campus activity to attend with a peer to instead choosing an on campus activity to attend with staff. His IDT agreed that this was already something that he was able to do. His previous relationship goal had never been implemented.

2. Of the 22 personal goals that met criterion for indicator 1, 18 also met criterion for measurability. The goals that also met this criterion were:

- Individual #114's goals for recreational/leisure, relationships, work/day, and greater independence.
- Individual #207's goals for recreation/leisure, relationships, work/day, greater independence, and living options.
- Individual #191's goals for recreation/leisure, greater independence, and living options.
- Individual #100's goal for greater independence.
- Individual #142's greater independence goal.

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.

3. One of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her

overall personal goals. As noted throughout this report, for all of the other goals, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of data and documentation provided by the facility. While there were some data collected showing implementation of some action plans, there was not enough information documented to clearly determine the status of goals. The goal where implementation data were documented was:

- Individual #100's goal for greater independence.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.

Summary: Overall, signs of improvement can be teased out of these scores. Three indicators showed slight scoring improvement and one showed a slight decrease compared with the last review. The sub-scores for indicator 8 showed improvement from five to 11 goals meeting criteria for having action plans designed to support achievement of the goal. Indeed, this was one of the areas of focused attention for the QIDP coordinator and the QIDPs over the past few months. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 191	114	100	207	154	142			
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	2/6	1/6	4/6	2/6	1/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	67% 4/6	0/1	0/1	1/1	1/1	1/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	1/1	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.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement	0%	0/1	0/1	0/1	0/1	0/1	0/1			

	throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0/6									
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	0/6	0/6	0/6	2/6	0/6			

Comments:

8. Eighteen of the personal goals met criterion in the ISPs, as described above in indicator 1, therefore, those action plans could 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.

Action plans, for the most part, did not support accomplishment of the individuals' personal goals. Many skill acquisition programs were never developed and for the ones that were, they did not include enough information to ensure that staff could consistently implement them and determine what progress was made. Service objectives did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress. The QIDP Coordinator had begun gathering data regarding compliance with the indicator. She acknowledged that compliance was low and planned to focus training efforts in the area.

For the 22 personal goals that met criterion under indicator 1, 11 had action plans that were likely to lead to the accomplishment of the goal. This was an improvement from the last review when five met this criterion (and was a recent focus of the QIDP Coordinator). Even so, IDTs were struggling with developing action steps that would lead to measurable progress towards goals. For the most part, greater independence goals had skill acquisition plans that provided enough direction for staff to consistently implement the action plan and measure progress. IDTs struggled with developing action plans for goals in other areas. Goals that met criterion were:

- Individual #114's relationship and greater independence goals.
- Individual #207's recreation, relationship, greater independence, and living option goals.
- Individual #191's greater independence goal.
- Individual #100's greater independence goal.
- Individual #154's recreation and greater independence goal.
- Individual #142's greater independence goal.

9. None of the ISPs had action plans that integrated preferences and opportunities for choice. IDTs either failed to adequately identify their preferences through the assessment process or did not develop opportunities for meaningful choice throughout their day.

10. None of these six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. A basis to making informed decisions is offering individuals exposure to a variety of new experiences and opportunities to make choices throughout their day. These opportunities were not included in action plans in any substantial way.

The facility's self-advocacy committee was meeting each week. The Monitoring Team attended the meeting during the onsite week, as it

usually does. Even more so than last time, the meeting was better attended than any committee meeting observed over the past few years (about 25 individuals). The new HRO facilitated the meeting. As discussed with the HRO after the meeting, self-advocacy meeting can be one type of opportunity for individuals to work on decision-making and problem-solving skills. Also, splitting up into smaller groups during the meeting to work on activities might engage more individuals in a more meaningful manner. The Monitoring Team looks forward to seeing the continued development of this committee.

11. Four of six ISPs met criterion for this indicator to support the individual's overall independence.
- Individual #191 did not have a functional skills assessment, so it was not possible to determine which skills he would need to gain to become more independent.
- Individual #114 had an action plan to wash his clothes. It appeared that he could already complete this independently.

12. Five of six ISPs did not integrate strategies to minimize risks in ISP action plans. As noted above, IDTs failed to develop specific teaching and support strategies to carry out action plans, thus, they did not have an avenue to integrate support strategies to address risks into action plans. In one positive example, however, Individual #191's ISP did integrate strategies to reduce his behavioral risk and his risk for poor oral hygiene.

Specific support strategies should be included in staff instruction for implementing action plans, when relevant, to minimize risks in all settings. For example,
- Individual #100 had an action plan for staff to brush his teeth. There were no strategies to support him to be more independent in his toothbrushing skills. His physical therapy recommendations were not integrated into action plans for work and community outings.
- Individual #154 also had an action plan for her teeth to be brushed. The team did not consider action plans to support her to be more independent in her dental care.
- Individual #114's nursing assessment included recommendations for exercise to address his weight risk. This recommendation was not addressed through his action plans.

Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. In particular, collaborative work was occurring between the QIDP coordinator and the Program Compliance Nurse to improve the quality of the content of the IHCP portion of the ISP. These professional staff presented two of their newest IHCPs and their plans for improvement to the Monitoring Team during the onsite week. The Monitoring Team was encouraged by this activity looks forward to seeing the results of these efforts at the time of the next onsite review.

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 most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. Examples where discipline assessments and recommendations were not fully integrated included:
- Individual #207's psychiatry and behavior supports were not integrated into his action plans to support his work/day goal. Further assessment (or re-assessment of his diagnosis of Prader-Willi Syndrome was also warranted).
- Individual #191 had a standalone communication goal to sign the word "outside." Communication strategies were not

integrated into other action plans.

- Individual #100's physical therapy strategies to transition back to walking from using his wheelchair and dining strategies were not integrated into his new ISP goals and action plans.
- Individual #154's physical therapy recommendations were not integrated throughout her goals and action plans to address her risk for falls. Her occupational therapist noted a functional decline in cognitive skills. This was not addressed by her IDT.
- Recommendation to address Individual #142's risk for falls were not integrated into his action plans for community outings.

14. Meaningful and substantial community integration was absent from five of six ISPs. Individual #114's had a goal to join a community fishing group. This would have been a great opportunity for meaningful engagement and integration in the community, however, the goal had not been implemented. Although other individuals had opportunities to go into the community and outings were documented, none of the individuals had formalized training with adequate teaching strategies that might lead to integration into the community.

Individuals were not given opportunities to utilize community resources that might support them to be more independent and integrated into the community. For example, none of the individuals had goals for banking, volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movie, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. Four ISPs did not include action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #154, Individual #142, Individual #114, and Individual #191's ISPs did not adequately define their preferences related to work and day programming.

Training opportunities were limited and rarely individualized. Individuals had few opportunities to learn new skills and experience new things. This was particularly true regarding employment. Work opportunities were limited to the few contracts available at the workshop. There was no process in place to assess job skills and preferences outside of the contracts at the workshop.

- At Individual #191's ISP preparation meeting, the IDT acknowledged that Individual #191 had many good work skills and consistently worked four to six hours a day the previous ISP year on contract work at the workshop. The IDT agreed that he would continue his contract work for the next year. There was no consideration of assessing him to see if he might be able to work at a job based on his preferences making real wages.
- Similarly, at Individual #100's ISP meeting, the IDT acknowledged that Individual #100 enjoyed work and had good job skills. He made $6.10 the previous year doing contract work at the workshop. The team also agreed that he would continue working on the same contract for the upcoming ISP year. Again, the IDT did not consider assessing his work skills and offering job skill training that might lead to supported employment in a minimum wage job.

16. ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional skill development. The assessment process was not adequate for assessing interests and skills outside of the limited training activities available at the facility.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Individual #191's ISP preparation meeting was observed. The IDT reviewed his goals and noted that most of his action plans were never fully implemented. They did not address the previous year's barriers to implementation or to progress.

18. Two of the action plans described detail about data collection and review (Individual #154). 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 most 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, performance remained about the same as at the last review. That being said, 100% performance was demonstrated again for indicator 24, which is about identifying obstacles to referral. Therefore, indicator 24 will be moved to the category of requiring less oversight. The next step is to develop (and implement) actions to address those obstacles. The other indicators of this outcome will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 191	114	100	207	154	142			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	67% 4/6	1/1	0/1	1/1	1/1	0/1	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.	0% 0/2	N/A	N/A	0/1	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	50% 3/6	1/1	1/1	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.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	1/1	0/1	0/1	1/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	0% 0/2	N/A	N/A	0/1	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	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			

	referred, to transition.										
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/2	N/A	N/A	0/1	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	0/1	0/1	N/A	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. Living option goals were developed to support individual's preferences in four ISPs. IDTs, however, were still struggling to develop individualized action plans that were likely to lead to the accomplishment of those goals, thus, little progress had been made towards achieving living option goals.

- For Individual #114 and Individual #154, the ISP noted that their living option preferences were largely unknown. The IDT did not use the knowledge of the staff who knew them the best to document their known preferences related to living environment.

20. The Monitoring Team observed the annual ISP meetings for Individual #100 and Individual #290. For Individual #100, the team agreed that he should remain at the facility. He was temporarily moved to another home for greater access to nursing supports following surgery. The team agreed that he would move back to home 672, without consideration of other living options that might support his preferences and needs.
Individual #290's team noted that she said "no" when asked if she wanted to continue to live at the SSLC, however, it is unlikely that this was an adequate way to solely assess her preference. She did not have an LAR, but had active family members whose preference was for her live at the SSLC.

21. Three ISPs included the opinions and recommendation of the IDT's staff members. For Individual #207, Individual #154, and Individual #142, assessments that included living option recommendations were not submitted prior to the ISP meeting for consideration or recommendations were absent.

22. All ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.

23. Two of the individuals (Individual #207, Individual #191) had a thorough examination of living options based upon their preferences, needs, and strengths. Other ISPs did not document discussion of community living options that might support their preferences and needs.

24. 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 #100 and Individual #290, whose ISP meetings were observed during this onsite visit, the IDTs did not identify obstacles to referral.

26. One of six individuals (Individual #191) had individualized, measurable action plans to address obstacles to referral.
    - For the most part, action plans to address individual awareness and LAR reluctance did not have individualized measurable action plans with learning objectives or outcomes.
    - Individual #114's IDT identified his family's wishes as the sole obstacle to referral. The team did not develop action plans to educate the family on living options in the community.
    - Individual #142's team noted that the IDT would need to clarify his options due to past criminal charges against him. They did not develop action plans related to this recommendation.

27. During Individual #100 and Individual #290's annual ISP meetings observed onsite, the IDTs did not discuss or develop meaningful or measurable action plans to address their lack of awareness of community living options.

28. None of the ISPs had individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs when lack of awareness was identified as a barrier.

29. None of the individuals were referred to the community.

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

Summary: ISPs were revised annually and, for new admissions, developed within 30 days of admission. This has been the case for all individuals for this review and the three previous reviews, too, with one exception in August 2016. Therefore, indicators 30 and 31 will be moved to the category of requiring less oversight. It was good to see individuals participating/attending their annual meetings. Attention should be paid to ensuring that IDT members who should attend the ISP meeting do attend the meeting. Indicators 32, 33, and 34 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	191	114	100	207	154	142			
30	The ISP was revised at least annually.	100% 5/5	1/1	1/1	1/1	N/A	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	N/A	N/A	1/1	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).	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			

34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			

Comments:

30. All ISPs were updated and revised annually.

31. Individual #207 was re-admitted to the facility over the past year. His ISP was developed within 30 days of his re-admission.

32. Documentation was not submitted that showed that action plans were implemented within a timely basis. QIDP monthly reviews indicated that a majority of goals were either never implemented or not consistently implemented. This is a repeat finding from the last review.

33. Five individuals attended their ISP meetings. Individual #154 did not attend her ISP meeting.

34. One individual (Individual #154) had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.

- Overall, participation was good among individuals and their LARs.
- For Individual #114, psychiatry did not participate in his ISP meeting or submit a comprehensive assessment at least 10 days prior to his meeting for review by his IDT.
- Psychiatry was also absent from Individual #207, Individual #142, and Individual #191's annual ISP meetings, though all received psychiatric services that impacted their support needs.

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

Summary: It was good to see progress to 100% for indicator 35 regarding determining needed assessments. The next step is to ensure that those assessments are obtained (indicator 36). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	191	114	100	207	154	142			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	100% 5/5	1/1	1/1	1/1	N/A	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 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 all individuals. Individual #207 was recently re-admitted, thus, he did not have an ISP preparation meeting where that discussion would be documented.

36. None of the IDTs then arranged for and obtained all needed, relevant assessments as identified by the IDT prior to the ISP meeting.
- Individual #114's vocational and psychiatry assessments were not submitted at least 10 days prior to his ISP meeting according to QIDP data.
- Individual #207's behavioral assessment and vocational were not submitted timely.
- Individual #191's functional skills assessment, PSI, and vocational assessments had not been updated prior to his ISP meeting according to QIDP data regarding assessment submission.
- Individual #100's vocational assessment was not adequate for determining his preferences and support needs related to work.
- Individual #154's nursing, behavioral, functional skills, annual medical, and comprehensive psychiatry assessments were not timely per QIDP data.
- Individual #142's behavioral and functional skills assessment assessments were not timely.

The facility needs to develop a plan to ensure that assessments are available to IDT members at least 10 days prior to the ISP meeting for review. Without assessment information available to the team, it is unlikely that all supports will be developed to address preferences, needs, and risks at the annual ISP meeting.

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

Summary: IDTs met routinely, however, progress was not adequately being reviewed by QIDPs and IDTs. Consequently, actions were not developed or taken. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	191	114	100	207	154	142			
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 routinely when a serious incident occurred. This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure that recommendations were implemented. Furthermore, reliable and valid data were rarely available to guide decision-making.

IDTs rarely revised goals when progress was not evident. ISPs were not fully implemented for any individual. IDTs sometimes discontinued goals that were not being implemented, however, did not meet to revise goals or address barriers to prior 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. 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. This is a repeat finding from the last review, progress was not evident.

Some QIDP monthly reviews included data for some action plans, but did not include an analysis of those data to determine what specific progress had been made towards achievement of goals. Information regarding behavioral supports, habilitation therapy, and medical supports was inserted in the monthly reviews without a summary of status, statement on the efficacy of supports, or efforts made to follow-up on outstanding issues. There was little documentation of follow-up when plans were not implemented or not effective. This practice places individuals at significant risk for harm when the IDT cannot determine if supports to address risks are consistently implemented or effective.

The Monitoring Team attended a number of meetings while onsite to review the IDT process and the facility response to incidents. At all meetings, reliable data were not available for review to facilitate decision making and ensure that supports were revised when not effective.

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.

Individuals:

#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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.	56% 10/18	1/2	2/2	2/2	0/2	2/2	2/2	0/2	1/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 17 IRRFs addressing specific risk areas [i.e., Individual #207 – respiratory compromise, and weight; Individual #114 – polypharmacy/side effects, and aspiration; Individual #136 – aspiration, and circulatory; Individual #112 – gastrointestinal (GI) problems, and respiratory compromise; Individual #154 – dental, and fractures; Individual #256 – choking, and osteoporosis; Individual #353 – infections, and seizures; Individual #142 – falls, and skin integrity; and Individual #348 – constipation/bowel obstruction, and infections].

a. None of the IDTs effectively used supporting clinical data when determining a risk level. Most used the risk guidelines in determining

risk level.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs for individuals within 30 days of admission and updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #207 – weight; Individual #114 – polypharmacy/side effects, and aspiration; Individual #136 – aspiration, and circulatory; Individual #154 – dental; Individual #256 – choking, and osteoporosis; and Individual #142 – skin integrity.

Psychiatry

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

Summary: San Antonio SSLC continued to make progress towards having psychiatry-related goals that met criteria. Over the past review period, the two new psychiatrists were primarily addressing putting into place a stable psychiatry service department after years of turnover and locum tenens appointments. It is likely that continued progress will be seen. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
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.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
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:
The San Antonio SSLC psychiatry department had begun to identify psychiatric indicators for individuals. This will allow them to begin to develop goals based on these indicators. This outcome contains four indicators that each get at an important aspect of the goals. Each will be discussed in turn below.

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

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

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder. Psychiatric indicators can be psychometrically sound rating scales, and/or data collection recordings of symptoms directly observed by SSLC staff. Psychiatric indicators need to be directly related (derived from) the individual's diagnosis or diagnoses. Individuals should have psychiatric indicators (and goals) that are related to the reduction of psychiatric symptoms and goals/objectives related to the increase of positive/desirable behaviors.

Goals for behavioral health services typically appear in the functional assessment and/or the PBSP. Goals for psychiatry typically appear in the annual psychiatry update and/or quarterly psychiatry clinic review reports. Goals for behavioral health services and for psychiatry ultimately need to appear in the behavioral health risk section of the IHCP.

4. The Monitoring Team looks at the set of goals for each individual. Goals must include the focus of the goal (i.e., psychiatric indicators), address the reduction of symptoms and the increase of prosocial behaviors, and include criterion.

At San Antonio SSLC, none of the individuals' goals met all of the criteria, however, there was some progress as described in some detail below, along with specific feedback and suggestions from the Monitoring Team.

- Two individuals had goals with a desired number of occurrences (e.g., two or less episodes per month, 80% of opportunities per month), and a length of time (e.g., six consecutive months). This was good to see, but needs to be applied to all goals for all individuals. The goals also need to have a desired end time (e.g., by December 31, 2018). None of them had this latter item.
- There was a need for improvement regarding the operational definitions of the psychiatric indicators. For example, rather than solely writing "depression," the indicator should define depression for the individual (e.g., "relates to his feelings, crying, anhedonia, sleep disturbances and weight loss which is directly correlated to when his mother does not visit him"). This, however, was not the case for the psychiatric indicators.
- Goals need to appear in the IHCP section of the ISP. This was not yet the case.

5. Goals must be measurable. That is, the psychiatric indicators in each goal must be observable and measurable. They must be designed so that their reliability can be determined.

- In order for the goal to be measurable, the definition (operationalization) needs to clearly describe exactly what it is that the person recording information needs to see. This is typically direct support professional staff, but sometimes might be behavioral health services staff or psychiatry staff (e.g., for rating scales). Those recorders need to know how to determine if a

psychiatric indicator (symptom) is or is not occurring and if it should or should not be counted.

6. Goals (and their psychiatric indicators) must be related to the individual's assessment and diagnosis.
   - The Monitoring Team does not require that there be a separate goal for reduction and a separate goal for increase for every diagnosis.
   - Two individuals, Individual #354 and Individual #184, were scored a 1. Both of these individuals had a diagnosis of Intermittent Explosive Disorder with identified indicators of aggression and self-injurious behavior. Though that being said, they did not have positive prosocial indicators identified.
   - For individuals with autism, a psychiatric indicator for treatment with medications could be irritability. In these cases, it is fine for aggression to be an additional psychiatric indicator (it already was a target behavior in the PBSP).

7. Reliable and valid data need to be available so that the data can be used by the psychiatrist to make treatment decisions. Often, the data are presented in graphic or tabular format for the psychiatrist. Data need to be shown to be reliable. Reliability assessments are often done by behavioral health services, residential, or psychiatry staff. In addition to using data on psychiatry goals/indicators, psychiatrists often utilize behavioral health services target/replacement behavior data when making treatment decisions.
   - Reliable data were not reported for behavioral health services target and replacement behaviors for individuals who were seen by psychiatry.
   - There was no system to adequately collect or assess the reliability of the data on psychiatric indicators (that were not also target behaviors in the PBSP).
     - For example, there were problems with the reliability/accuracy of sleep data. This is an especially important piece of data for psychiatrists and should be one of the easier pieces of data to collect. But this was not the case at San Antonio SSLC.
   - Ensuring reliable data is an area of focus for the psychiatry department. Likely, accomplishing this will require collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Performance was about the same as last time, but is expected to improve with stability in the psychiatry department. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 125	274	290	191	114	100	354	207	184
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	0/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the	50% 1/2	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	0/1

	primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.										
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.	33% 3/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1

Comments:
14. The Monitoring Team looks for 14 components in the CPE. The evaluations regarding Individual #184, Individual #191, and Individual #114 met all the requirements. Six of the other evaluations lacked a sufficient bio-psycho-social formulation. This was the most common deficiency. Three evaluations were lacking sufficient information in one element, two evaluations were lacking sufficient information in two elements, and one evaluation was lacking sufficient information in five elements.

15. For the two individuals admitted in the two years prior to the onsite review, one had a psychiatric evaluation performed within 30 days of admission. Only one individual had integrated progress notes from primary care or nursing documenting an admission assessment completed within the first business day of admission.

16. There were six individuals whose documentation revealed inconsistent diagnoses: Individual #125, Individual #274, Individual #290, Individual #191, Individual #114, and Individual #184.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
17	Status and treatment document was updated within past 12 months.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	N/A
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	N/A
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	11% 1/9	0/1	0/1	1/1	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:
17-19. The Monitoring Team scores 16 aspects of the annual evaluation document. Seven individuals required annual evaluations. None were completed. The Monitoring Team scored indicator 19 based upon completion of a quarterly review within 90 days of the ISP

meeting.

20. The psychiatrist attended the ISP meeting for one of the individuals in the review group. There needs to be some documentation that the psychiatrist participated in the decision to not be needed to attend the ISP meeting; this can be by the psychiatrist attending the ISP preparation meeting, or by some other documentation/note that occurs prior to the annual ISP meeting. Even so, in the three-month period between the ISP preparation meeting and the annual ISP meeting, the status of the individual may have changed, there may have been psychiatric-related incidents, a change in medications, and so forth.

Thus, in looking at the status of the remaining eight individuals, the Monitoring Team determined that there was insufficient rationale for there being no psychiatry participation in the annual meeting for seven of the individuals (all except Individual #290 who was reportedly psychiatrically stable). Five individuals had polypharmacy medication regimens (Individual #125, Individual #274 Individual #191, Individual #207, Individual #184), one was a new admission (Individual #184), and two (Individual #114, Individual #100) were experiencing psychotic symptoms.

20. Based on ISP documentation, there was a need for improvement with regard to the psychiatrist's attendance at the ISP meetings. The presence of the psychiatrist always allows for richer discussion during the ISP with regard to the required elements.

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: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	33% 1/3	1/1	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A

Comments:
22. Three individuals in the review group, Individual #125, Individual #274 and Individual #100, had a PSP. The PSPs for Individual #274 and Individual #100 were monitoring different psychiatric indicators than those documented by psychiatry.

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

Summary: Side effect consent content and HRC review indicators met criteria for all individuals for this review and the previous two reviews, too, with one exception in August 2016. Therefore, indicators 29 and 32 will be moved to the category of	Individuals:

requiring less oversight. With sustained high performance, indicator 28 might also be moved to this category after the next review. Improvement was needed in the risk benefit and the non-pharmacological intervention content. These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	89% 8/9	1/1	1/1	0/1	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: 29. The consent forms included adequate medication side effect information. 30. The risk versus benefit discussion was not included in the consent forms, but needs to. 31. The consent forms did not include individualized alternate and non-pharmacological interventions outside of the PBSP and structured milieu.											

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: San Antonio SSLC did not have a data collection system that generated reliable, accurate, and valid data (indicators 5 and 26-30). This was also the case at the last review. This should be a priority for the behavioral health services department. Its absence is a barrier to meeting criteria with a number of indicators in psychology/behavioral health and to there being no need for a deeper review for some individuals. Indicator 5 will remain in active monitoring. One important target behavior (bullying) for one individual was not adequately defined, but even so, indicator 3 will remain in the category of requiring less oversight.			Individuals:								
#	Indicator	Overall	125	274	290	191	114	100	354	207	184

		Score									
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	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.										
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/7	0/1	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1

Comments:
3. Individual #125's bullying target behavior was not operationally defined and, therefore, scored as not measurable.

5. All individuals had interobserver agreement (IOA) and data timeliness data that the facility said that the data were reliable. But, the data collection system for all individuals' target and replacement behaviors did not directly lend itself to an adequate assessment of data collection timeliness (e.g., the absence of any data was interpreted to mean data were 100% reliable). 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 prior to the next onsite review. There were also problems with the data collection system in terms of validity (see indicators 26-30).

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

Summary: Given sustained high performance, indicator 10 will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 125	274	290	191	114	100	354	207	184
10	The individual has a current, and complete annual behavioral health update.	89% 8/9	1/1	1/1	1/1	1/1	0/1	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. Individual #114's behavioral health assessment did not include an intellectual assessment.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.												
Summary: Due to sustained high performance, indicator 13 will be moved to the category of requiring less oversight. Indicator 15 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 7/7	1/1	N/A	1/1	1/1	1/1	N/A	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.	86% 6/7	0/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1
Comments: 15. Individual #125's PBSP was not clearly based on his functional assessment.												

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

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.	
Summary: Given that during past reviews and this review, newly-admitted individuals reviewed had timely medical assessments (Round 9 – 100%, Rounds 10 – 100%, Rounds 11 and 12 – N/A, and Round 13 - 100%), Indicator a will move to the category requiring less oversight. For the individuals reviewed, annual medical assessments were generally timely as well. If the Center sustains this progress, Indicator b might move to the category of less oversight at the time of the next review. IDTs should continue to work towards defining the frequency of interim medical reviews in individuals' ISPs/IHCPs based on current standards of practice, and accepted clinical pathways/guidelines.	Individuals:

#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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.	88% 7/8	N/A	1/1	1/1	0/1	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	11% 1/9	1/1	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 a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. It was good to see that some of the IHCPs reviewed defined the frequency of medical review (i.e., for Individual #207 – aspiration; Individual #136 – seizures; Individual #353 – GI problems; Individual #142 –polypharmacy/ medication side effects; and Individual #348 – cardiac constipation/bowel obstruction, and seizures). However, not all IHCPs reviewed defined these parameters, and for some individuals, the IHCPs did not include frequencies consistent with the level of acuity of the chronic condition or risk (e.g., Individual #136 for chronic kidney disease, Individual #142 – diabetes).

In its comments on the draft report, the State disputed two of these findings. Specifically, the State indicated that Individual #142 had a six-month review. As the draft report indicated, a six-month review was not consistent with the level of acuity of Individual #142's diabetes. The State indicated that Individual #114 had quarterly reviews as defined in the AMA. However, the IDT had not approved this frequency and memorialized it in the IHCP. Per the audit tool, the Monitoring Team uses the IHCP to guide its review of the frequency of interim medical reviews.

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

Summary: Center staff should continue to improve the quality of the medical assessments. Indicators a and c will remain in active oversight.

Individuals:

#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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 the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the

individuals reviewed, all annual medical assessments addressed past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, and updated active problem lists. Most, but not all included, as applicable, pre-natal histories, social/smoking histories, complete physical exams with vital signs, and pertinent laboratory information. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, 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 #207 – aspiration, and diabetes; Individual #114 – other: cataracts, and other: macrocytosis; Individual #136 – seizures, and other: chronic kidney disease; Individual #112 – diabetes, and osteopenia; Individual #154 – constipation/bowel obstruction, and cardiac disease; Individual #256 – diabetes, and cardiac disease; Individual #353 – osteoporosis, and gastrointestinal (GI) problems; Individual #142 – diabetes, and polypharmacy/medication side effects; and Individual #348 – cardiac constipation/bowel obstruction, and seizures].

As noted above, some of the ISPs reviewed defined the frequency of medical review (i.e., for Individual #207 – aspiration; Individual #136 – seizures; Individual #353 – GI problems; Individual #142 –polypharmacy/ medication side effects; and Individual #348 – cardiac constipation/bowel obstruction, and seizures). However, problems were noted with regard to timeliness, as well as quality (e.g., lack of plans for medical issues identified, lack of reference to relevant diagnostic information, etc.).

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. On a positive note, some of the ISPs reviewed defined the frequency of medical review. These indicators will remain in active oversight.

			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	33% 6/18	1/2	0/2	1/2	0/2	0/2	0/2	1/2	1/2	2/2

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (Individual #207 – aspiration, and diabetes; Individual #114 – other: cataracts, and other: macrocytosis; Individual #136 – seizures, and other: chronic kidney disease; Individual #112 – diabetes, and osteopenia; Individual #154 – constipation/bowel obstruction, and cardiac disease; Individual #256 – diabetes, and cardiac disease; Individual #353 – osteoporosis, and GI problems; Individual #142 – diabetes, and polypharmacy/medication side effects; and Individual #348 – cardiac constipation/bowel obstruction, and seizures).

The IHCPs that sufficiently addressed the chronic or at-risk condition in accordance with applicable medical guidelines, or other current

standards of practice were for Individual #353 – GI problems, and Individual #348 – seizures.

b. As noted above, it was good to see that some of the ISPs reviewed defined the frequency of medical review (i.e., Individual #207 – aspiration; Individual #136 – seizures; Individual #353 – GI problems; Individual #142 –polypharmacy/medication side effects; and Individual #348 – cardiac constipation/bowel obstruction, and seizures).

Dental

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

Comments: Given that during past reviews and this review, newly-admitted individuals reviewed had timely dental exams and summaries (Round 9 – 100%, Round 10 – 100%, Rounds 11 and 12 – N/A, and Round 13 - 100%), and individuals reviewed generally had timely annual dental summaries (Round 11 – 88%, Round 12 – 100%, and Round 13 - 100%), Indicators a.i and a.iii will move to the category requiring less oversight. The Center should focus on ensuring that dental exams are completed within 90 days prior to individuals' ISP meetings. Although continued work was needed, good progress was noted with regard to the quality of dental exams and summaries. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 207	114	136	112	154	256	353	142	348
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	38% 3/8	N/A	0/1	1/1	0/1	0/1	1/1	1/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	67% 6/9	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	33% 3/9	1/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1

Comments: a. For five of the eight individuals reviewed, dental exams were completed more than 90 days prior to the ISP meeting. This should be corrected, as it results in the IDTs having outdated information with which to develop individuals' ISPs.

It was positive that for all individuals reviewed, dental summaries were completed no later than 10 working days prior to the ISP meeting.

b. It was positive that six of the nine dental exams reviewed included all of the required components. The remaining dental exams were missing a summary of the number of teeth present/missing.

c. Overall, dental summaries did not include signatures or an indication of who completed them. This issue needs correction.

On a positive note, the dental summaries for Individual #207, Individual #114, and Individual #154 included all of the required components. In addition, all of the dental summaries included the following:

- Effectiveness of pre-treatment sedation;
- Recommendations related to the need for desensitization or another plan;
- Dental care recommendations;
- Treatment plan, including the recall frequency;
- Provision of written oral hygiene instructions; and
- Recommendations for the risk level for the IRRF.

Most included:

- A description of the treatment provided;
- 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.

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

- Dental conditions that could cause systemic health issues or are caused by systemic health issues.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
Summary: Although some improvement was noted with regard to the inclusion of Braden scores, full physical assessments were not documented for a number of individuals (i.e., missing were fall assessments, weight graphs, reproductive assessments, and follow-up to abnormal vital signs). The remaining indicators 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. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348

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.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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% 0/7	N/A	0/1	0/1	0/1	0/1	0/1	N/A	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.	0% 0/7	0/1	N/A	N/A	N/A	0/1	N/A	0/2	0/1	0/2

Comments: a. Based on the Monitoring Team's review of annual and quarterly nursing assessments and physicals, problems were noted for all nine individuals with regard to completion of thorough physical assessments, including fall assessments, weight graphs, and assessments of reproductive systems. In addition, abnormal findings (e.g., vital signs, pain) often did not result in further analysis, narrative, or follow-up. On a positive note, improvement was noted with regard to the inclusion of Braden scores.

Some of these issues appeared to be related to IRIS, and the State Office Discipline Lead was working to make changes to the system. However, other issues were unrelated to IRIS, and require corrections on the part of Center staff.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #207 – respiratory compromise, and weight; Individual #114 – polypharmacy/side effects, and aspiration; Individual #136 – aspiration, and circulatory; Individual #112 – GI problems, and respiratory compromise; Individual #154 – dental, and fractures; Individual #256 – choking, and osteoporosis; Individual #353 – infections, and seizures; Individual #142 – falls, and skin integrity; and Individual #348 – constipation/bowel obstruction, and infections).

At the time the ISP was due, Individual #353 was hospitalized, so the completion of assessments was postponed. 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 7/15/17, Individual #154 was diagnosed with fractures of the right humerus, right clavicle, and compressed lumbar vertebra. On 7/15/17, nursing staff followed relevant standards to assess the presenting signs and symptoms, and document the findings. The record indicated a date and time of physician notification. However, upon her return to the Center, problems were noted with regard to nursing staff documenting findings in IPNs related to the circulation of her right arm/splint, providing descriptions of when edema was present, and correlating findings between IView and IPNs. In addition, the individual was prescribed a narcotic for pain, for which nursing staff did not consistently follow Center guidelines for following up and uniformly measuring the individual's pain, such as through use of the FLACC scale. Also, a Braden Assessment was not found upon her return from the ED. An acute care plan was not found in the records.
- On 9/9/17, Individual #353 went to the ED for redness, tenderness, and purulent drainage around the stoma site. On 9/9/17, he returned to the Center with a diagnosis of cellulitis around the stoma site, and was prescribed antibiotics and Tylenol for pain. The initial nursing IPN documented a nursing assessment in alignment with the individual's signs and symptoms and observation of the G-tube stoma, as well as appropriate notification to the physician, including notification of the individual's elevated blood pressure and pulse. Similarly, upon the individual's return from the ED, the initial follow-up nursing IPNs and IView entries followed nursing standards of care based on the individual's signs and symptoms. However, additional follow-up nursing IPNs did not show that nurses followed the guidelines for antibiotic therapy, and/or for assessing the individual on the last day of antibiotic therapy. In addition, nursing staff did not document providing direct support professional staff with instructions to monitor for signs of a potential drug reaction. An acute care plan was not found in the records.
- Between 8/6/17 and 10/12/17, Individual #353 had 13 seizures. Overall, nursing seizure guidelines were followed for vital signs after seizures and for assessing respiratory status, and nursing staff followed physician orders for the administration of Lorazepam intramuscular (IM). However, nursing staff did not follow the post-sedation protocol for vital signs after the use of Lorazepam. The nursing IPNs/IView documentation also did not include mental status or level of consciousness.
- On 10/12/17 at 10:05 p.m., nursing staff wrote an IPN documenting an assessment of Individual #348 for the occurrence of a constipation episode. The individual refused vital signs, but the nurse did not document a respiratory rate, an assessment of pain, or an assessment of lung sounds, as the constipation guidelines require.
- On 8/22/17, Individual #348 had surgery to drain an abscess on his left hip, and a culture showed the wound was infected by methicillin-resistant Staphylococcus aureus (MRSA). On 8/28/17, he was discharged from the hospital with a prescription for oral antibiotics. Prior to the transfer to the ED, nursing staff did not follow relevant nursing guidelines related to a skin assessment. After the hospitalization, nursing assessment documentation included inaccurate statements. For example, for the initial post-hospital assessment, dated 8/28/17 at 9:07 p.m., the IView Incision/Wound and dressing change entry noted the wound was on the individual's breast, but the wound was on the left hip. This same inaccurate information was repeated more than once in the IVIEW documentation. An acute care plan was not found in the records.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.	
Summary: Given that over the last several review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These	Individuals:

indicators will remain in active oversight.											
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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. None of the IHCPs reviewed comprehensively set forth plans to address their existing conditions, including at-risk conditions.											

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, and the PNMT discussed the results. If the Center sustains this progress, at the time of the next review, the related indicator might move to the category requiring less oversight. Since the last review, the scores during this review generally remained the same or regressed. The Center should focus on ensuring referral of all individuals that meet criteria for PNMT review, timely completion of the PNMT initial review, completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment and documentation of their involvement, and the quality of the PNMT comprehensive assessments. These	Individuals:

indicators will remain in active oversight.											
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	75% 3/4	N/A	1/1	N/A	N/A	0/1	N/A	1/1	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 2/4		1/1			0/1		1/1	0/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	33% 1/3		N/A			0/1		1/1	0/1	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	50% 2/4		1/1			0/1		1/1	0/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 1/1		N/A			N/A		1/1	N/A	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/4		0/1			0/1		0/1	0/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/3		0/1			0/1		N/A	0/1	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3		N/A			0/1		0/1	0/1	

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

- Although fall data for Individual #114 varied depending on which document one reviewed, it appeared that the PNMT reviewed him prior to his technically meeting criteria for review, which was good to see. In terms of the consistency of the data:
  - The Episode Tracker indicated that he had the following number of falls per month in 2017: one - July, four - August, two - September, one - October, three - November, and two – December.
  - Documentation the Center submitted as part of its response for Tier I documents, showed he fell two times in October (i.e., 10/5/17, and 10/6/17), as opposed to once.

- In response to the Monitoring Team's request, the Center submitted Document #TX-SA-1802-Section IV. This document showed falls on the following dates: 8/8/17, 8/14/17, 8/17/17, 8/24/17, 9/12/17, 9/21/17, 9/29/17, 10/22/17, 11/6/2017, 11/14/17, and 12/3/17.
- This document further showed referrals to the PNMT for falls on 10/5/17, 11/9/17, and 11/16/17, but other documentation submitted did not confirm the last two referrals.

The review the PNMT conducted for Individual #114 included a section on history/background of the problem, but the PNMT did not provide enough information regarding the frequency of his previous falls, actions the IDT took (i.e., it just stated the IDT held two ISPA meetings), and/or information about previous PT assessments and interventions (e.g., when they were implemented and their effectiveness). The review stated that the PNMT would not conduct more assessment, but would monitor the PNMT log. No follow-up was noted to determine the effectiveness of the recommendations the PNMT offered.

- On 12/27/16, Individual #154's IDT referred her to the PNMT for weight loss. On 1/31/17, the PNMT completed an assessment, and on 8/4/17, the PNMT discharged her. In December 2016, she had aspiration pneumonia (i.e., hospitalization from 12/14/16 to 12/27/16), but the January 2017 PNMT assessment did not fully address this diagnosis. In addition, on 7/15/17, Individual #154 experienced three fractures, including fractures to her right clavicle, compressed lumbar vertebra, and a comminuted right distal humerus fracture. Because the clavicle and humerus are long bones, she met criteria for referral to the PNMT. The fracture of her spine also was a qualifying condition that required referral. The PNMT should have at least reviewed the circumstances related to these fractures, but did not. In addition to the lack of a comprehensive assessment of the incidence of aspiration pneumonia, the lack of a review made it unclear whether or not a comprehensive assessment was needed to address the fractures.
- On 6/21/17, Individual #353 was hospitalized and diagnosed with aspiration pneumonia. On 7/12/17, he was discharged from the hospital. An RN Post Hospitalization Review was completed, and the PNMT discussed the results, which was good to see. On 7/13/17, his IDT referred him to the PNMT, who reviewed him on the same day for respiratory compromise and new enteral nutrition. The PNMT completed a timely comprehensive assessment. The quality of this assessment is discussed below.
- In May 2017, the PNMT appropriately conducted a review of Individual #142 in relation to falls, but the review did not occur within five days of the referral (i.e., referral on 5/4/17, and review completed on 5/23/17). Based on information the Center provided, the fall data were inconsistent. For example:
  - According to Document #TX-SA-1802-Section IV, he fell on 8/11/17, 8/27/17, 8/28/17, 9/1/17, 9/2/17, 9/30/17, 10/9/17, 10/16/17 x2, 10/20/17, 10/22/17, 10/23/17, 11/7/17, 11/15/17, 11/23/17, 12/2/17, 12/4/2017, 1/7/18, and 1/11/18.
  - Although covering a slightly different time period, the Center provided the following list of falls for Individual #142 in its response to the Tier I document request: 6/4/17, 6/10/17, 6/20/17, 7/9/17 x2, 7/11/17, 7/17/17, 7/19/17, 7/22/17, 7/23/17, 7/25/17, 7/28/17, 8/11/17, 8/28/17, 9/1/17, 9/2/17,9/3/17, 9/13/17, 9/26/17, 9/30/17, 10/9/17, 10/16/17 x2, 10/20/17, 10/22/17, 10/23/17, 11/7/17, 11/21/17, 11/23/17, 11/25/17, 11/26/17, and 12/4/17.

Regardless of the discrepancies in data, his falls continued at a significant rate, and a comprehensive assessment was indicated, but the PNMT did not conduct one.

h. As noted above, two individuals who potentially should have had comprehensive PNMT assessments did not (i.e., Individual #154, and Individual #142). The following summarizes some of the findings noted with the assessment that the PNMT completed for Individual #353:

- Some positives included:
  - The assessment identified the presenting problem(s).
  - The PNMT discussed the applicable risk ratings, and discussed whether or not they needed to be modified and why.
  - The PNMT took into consideration Individual #353's behaviors as they related to physical and nutritional supports.
  - The PNMT also documented observations of the individual.
- A number of concerns were noted with the assessment. For example:
  - The PNMT included some confusing information, when it quoted the PCP as saying that Individual #353's medical diagnoses did not impact his aspiration risk and new enteral feeding tube. The PNMT later indicated that the recent cardiovascular accident (CVA) did contribute to this risk and the new tube.
  - Although the PNMT addressed one issue related to phenytoin that the neurologist identified, they did not address other potential issues related to medications.
  - Of concern, the PNMT identified the CVA as the underlying cause of the aspiration risk, but stopping there did not provide the IDT with the information it needed. Although the CVA might have been the cause of the changes that occurred to Individual #353's swallowing function, it was the changes themselves that increased his risk for aspiration. If the PNMT had continued to ask why (i.e., why/how did the CVA impact his swallowing?), they might have identified areas on which the IDT could work with the individual to reduce his risk. For example, the answer to that additional "why" might have been that the CVA reduced his ability to safely move boluses from the front to the back of his mouth. If that were the case, then knowing this might have assisted the IDT to develop a goal/objective and related therapy plan to assist Individual #353 in regaining some of this important function.

    In its comments on the draft report, the State disputed this finding, and stated: "The PNMT assessment outlines how the CVA impacted individual #353's swallowing. On page 16 of document TX-SA-1802-II.10. [Individual #353], the PNMT assessment states 'The stress of a CVA lowers an individual's immune system, and Individual #353's ability to swallow has been affected, as he is currently unable to swallow.' Thus, the swallowing difficulty is characterized by absent ability to swallow."

    As the Monitoring Team member discussed with the PNMT while on site, the PNMT did not bring the "root cause" to the functional impairment level, which is a level at which interventions might be identified to act to improve that function. In its comments, the State continued to describe the "root cause" of the swallowing issues as the CVA, and did not identify the specific functional impairment, which again, might lead to discussion of potential interventions.
  - Without a thorough assessment that identified the underlying cause(s) of Individual #353's physical and nutritional management needs, the assessment did not include a comprehensive set of recommendations.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.	
Summary: Since the last review, some improvement was noted with regard to the quality of PNMPs. No improvement was seen with regard to the remaining	Individuals:

indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. All of these indicators will remain in active oversight.											
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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% 0/19	0/2	0/2	0/2	0/2	0/3	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/19	0/2	0/2	0/2	0/2	0/3	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.	60% 6/10	1/2	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/19	0/2	0/2	0/2	0/2	0/3	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% 0/19	0/2	0/2	0/2	0/2	0/3	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% 0/19	0/2	0/2	0/2	0/2	0/3	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/19	0/2	0/2	0/2	0/2	1/3	0/2	1/2	0/2	0/2

Comments: The Monitoring Team reviewed 19 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 #207; weight, and falls for Individual #114; aspiration, and weight for Individual #136; aspiration, and fractures for Individual #112; aspiration, weight, and fractures for Individual #154; choking, and falls for Individual #256; falls, and aspiration for Individual #353; weight, and falls for Individual #142; and choking, and falls for Individual #348.

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

c. All individuals reviewed had PNMPs and/or Dining Plans. Individual #207 had a PNMP for part of the period reviewed, but on 10/31/17, the IDT discontinued it. The IDT continued his Dining Plan.

The Dining Plan for Individual #207, and the PNMPs for Individual #114, Individual #112, Individual #154, Individual #142, and Individual #348 included all of the necessary components to meet the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example:

- Individual #207's PNMP did not include bathing or toileting/personal care instructions.

- Individual #136's photographs had not been updated since 2014/2015.
- Individual #256's PNMP did not list his risk for falls/osteoporosis.
- In response to the request for the most current PNMP (i.e., #4), the Center did not submit page 2 of Individual #353's PNMP.

g. Often, the IHCPs reviewed did not include PNMP monitoring and/or define the frequency of monitoring. The exceptions were the IHCPs for fractures for Individual #154, and aspiration for Individual #353. In its comments on the draft report, the State argued that two other individuals' IHCPs defined the frequency of monitoring (i.e., Individual #136 and Individual #142). Upon review of the documents the State cited, the Monitoring Team confirmed that the IHCPs did not include interventions/action steps that defined the frequency of monitoring. The documentation to which the State referred were notes about some monitoring Habilitation Therapy staff completed. State Office should review with Center staff the difference between a plan defining action to be taken and documentation of actions that are implemented. Without the former, it is unclear whether or not the actions taken meet expectations.

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	207	114	136	112	154	256	353	142	348
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	N/A	0/1	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.	0% 0/2				0/1			0/1		
Comments: a. and b. Although Individual #112's and Individual #353's IRRFs indicated they were not candidates for a return to oral intake, their IDTs did not provide justification for these decisions.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.	
Summary: A significant issue was that Center staff had not followed the current guidelines for considering when an OT/PT comprehensive should be repeated. For a number of individuals reviewed, the three-year mark had passed, and OTs/PTs had not completed a new comprehensive assessment, or justified why an update	Individuals:

met the individual's needs. The comprehensive assessments and update reviewed needed improvement. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	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.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A

		0/8									
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

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

- On 6/16/17, Individual #207 transitioned to the community, but on 8/4/17, he returned to the Center. At that time, the OT/PT only completed an update as opposed to a new comprehensive assessment. Further, according to documentation the Center provided, on 8/16/17, 9/15/17, 10/2/17, and 10/3/17, Individual #207 fell. On 10/10/17, he was hospitalized for generalized weakness, malaise, numbness to his bilateral lower extremities, weight loss, and drooling. Upon his return, he required direct PT services to increase his ability to walk. However, the OT/PT still did not complete a comprehensive assessment.
- The following individuals' last comprehensive OT/PT assessments were completed at least three years ago: Individual #114, Individual #136, Individual #112, Individual #256, and Individual #142. Sufficient justification was not provided for not completing another comprehensive assessment. As a result, individuals did not have timely assessments and assessments that met their needs.
- At time of Individual #154 hospital discharge in December 2016 or prior to the initiation of direct therapy in January 2017 (PT), the OT/PT did not complete a comprehensive assessment. On 8/28/17, following an upper extremity fracture, the OT did complete a comprehensive assessment. The quality of the assessment is discussed below.

d. As noted above, for a number of individuals (i.e., Individual #114, Individual #136, Individual #112, Individual #256, and Individual #142), the OT/PT should have considered completing a comprehensive assessment (as opposed to an update), but did not, or did not provide clinical justification for not completing one. Individual #207 should have had a comprehensive assessment to address changes of status, but did not. The Monitoring Team reviewed Individual #154 and Individual #353's comprehensive OT/PT assessments. The following summarizes some of the problems noted:

- The individual's preferences and strengths were used in the development of OT/PT supports and services: Individual #353's preferences were not reflected in the recommendations for the development of skills or provision of supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: Individual #154's assessment listed these and suggested some change to levels, but did not address supports in relation to risk levels;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): Although Individual #154's assessment listed her adaptive equipment, it did not address effectiveness, fit, and working condition;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: Individual #154's assessment did not specify when monitoring was done or provide an analysis of data, but rather just concluded there were no concerns. For Individual #353, no evidence was provided of actual monitoring of the supports in place or data to confirm the effectiveness of the supports;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: For Individual #353, justification was provided for the initiation of PT services. However, the assessment did not justify why OT was not needed. For Individual #154, it was not clear why direct PT or OT (beyond splints and passive stretching of hands) were not indicated; and

- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, assessments were incomplete and recommendations that should have been made to address individuals' needs were not.

On a positive note, both of the comprehensive OT/PT assessments the Monitoring Team reviewed included, as applicable:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments; and
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living.

e. The following summarizes some examples of concerns noted with regard to the required components of Individual #348's OT/PT assessment:

- The individual's preferences and strengths are used in the development of OT/PT supports and services: The therapists did not address whether the lack of skills in some areas prevented Individual #348 from participating in some of his preferences;
- 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: Individual #348's's update lacked detail with regard to his fine motor skills;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: The assessment provided no specific monitoring findings or data to substantiate the effectiveness of supports;
- 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: The OT/PT did not provide specific data to confirm whether or not the individual was benefitting from the supports and services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: The therapists did not provide justification for the schedule of reassessment.

Of note, in its comments on the draft report, the State disputed some of these findings. Unfortunately, the State's comments underscored therapists' lack of understanding of the need to include specific data in assessments to substantiate findings and conclusions. The Monitor made no changes to the original findings.

On a positive note, as applicable, the update provided:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services; 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: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	25% 2/8	0/1	0/1	0/1	0/1	1/1	0/1	0/1	N/A	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	38% 3/8	0/1	0/1	0/1	0/1	1/1	1/1	0/1	N/A	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	9% 1/11	1/1	0/1	0/1	0/1	0/2	N/A	0/4	0/1	N/A
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	33% 1/3	1/1	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A
Comments: a. Most ISPs reviewed did not clearly describe the individuals' status related to ambulation, as well as their ability to complete activities of daily living. In its comments on the draft report, the State argued that Individual #348's ISP included such a description, and pointed to an excerpt from the OT/PT assessment on page 14 of the ISP as part of the Integrated Risk Discussion. Although the Monitor modified the score, IDTs should provide summaries of the individuals' functional status in a prominent place in the ISPs, so that it is easy for direct support professionals to quickly access a picture of the individuals' ability to ambulate, complete activities of daily living, etc. b. Simply including a stock statement such as "Team reviewed and approved PNMP" did not provide evidence of what the IDT reviewed, revised, and/or approved.										

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: Based on the Monitoring Team's review of annual communication assessments and updates for other indicators, the Center regressed with regard to the completion of timely annual communication assessments and updates in accordance with individuals' needs. As a result, Indicators a.iii and b will move back	Individuals:

to active oversight. Of additional concern, those assessments that were completed were generally of poor quality. The remaining indicators will remain in active oversight.											
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	Individual receives timely communication screening and/or assessment:	Due to the Center's sustained performance with these indicators, after Round 11, they moved to the category requiring less oversight. However, given that in a number of instances, SLPs did not complete timely annual communication assessments or updates in accordance with individuals' needs, Indicators a.iii and b will move back to active 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.	50% 1/2	0/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
d.	Individual receives quality Comprehensive Assessment.	0%	N/A	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1

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

Comments: a. and b. For a number of individuals reviewed, at least three years had passed since their last comprehensive assessment was completed, and per policy, the SLPs should have considered completing new comprehensive assessments. In some cases (e.g., Individual #114, Individual #136, Individual #112, Individual #256, and Individual #348), the rationale the SLP provided did not support the decision not to complete a new comprehensive assessment. For many of these individuals, although the SLP reported they had not had any change in functional communication skills, there had been enough change to justify the initiation of direct services or to recommend further expansion of existing skills (e.g., Individual #112, Individual #256, and Individual #136). Such findings should be sufficient to warrant a new comprehensive assessment in the third year. For Individual #348, the assessment indicated that staff reported no change in communication skills. The clinician should be responsible for making the determination of function in comparison with the previous comprehensive assessment. Such decisions should be made through assessment, and not solely on staff reporting their opinion regarding whether or not the individual has experienced changes. In addition, in making this decision, the clinician should compare the individual's current status with the previous comprehensive assessment, as opposed to the individual's status 12 months prior. Functional examples of how the individual communicated then and how he/she communicates at the time of the current update should be offered with analysis of why this was consistent and did not warrant a comprehensive assessment to reestablish the baseline. Individuals who were recommended for supports clearly had some level of change, and, as such, warrant a new assessment to document their communication baseline.

In its comments on the draft report, the State disputed a number of these findings. However, in most cases, the State did not cite the specific language in the assessments that it believed provided the justification that the Monitoring Team indicated was missing, or provided additional information that was not documented in the assessments reviewed. The Monitor's original findings stand.

For Individual #353, the update to the comprehensive assessment from 2015 stated that a comprehensive assessment could not be completed due to his hospitalization. However, it was not clear why in August 2017, the SLP did not complete a comprehensive assessment at the same time the OT/PT completed a comprehensive assessment to address his change of status.

c. It was positive that Individual #142's screening met the criteria, and addressed his communication strengths and needs. Individual #207's screening did not address his functional vision.

d. As discussed above, for the following five individuals, the SLPs' justifications did not support not completing new comprehensive assessments: Individual #114, Individual #136, Individual #112, Individual #256, and Individual #348. On 4/19/17, the SLP completed a comprehensive assessment for Individual #154 due to a change in status, and on 6/1/17, completed an update for an ISP meeting held on 6/21/17. The following describes some of the concerns with the assessment for Individual #154:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: The assessment did not provide the timeframes for the changes in her health status, and did not outline the impact these changes had on her communication;
- The individual's preferences and strengths are used in the development of communication supports and services: Due to changes in her status, a number of her preferences were no longer possible from an independent standpoint, such as reading,

and would have required accommodations. The assessment did not recommend interventions, and so her preferences were not addressed;

- A comparative analysis of current communication function with previous assessments: The assessment provided a limited picture of her skill level prior to the current decline;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: The SLP indicated that an EC evaluation was indicated, but did not complete one;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: Evidence was not present to show this occurred; 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: The SLP offered limited recommendations to address a drastic decline in Individual #154's communication skills. The only SAP the SLP recommended was for Individual #154 to point to what she wanted. The assessment did not offer sufficient rationale for not providing direct therapy, beyond saying that the individual became agitated with interactions and prompts. The SLP offered no strategies as to how to address this, and as noted above, the SLP did not appear to collaborate with Behavioral Health Services. Individual #154's issues appeared to be largely attributed to medication changes, but the SLP did not offer strategies to assist her in returning to baseline.

On a positive note, the assessment provided:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills; and
- The effectiveness of current supports, including monitoring findings: This was not applicable.

e. Similar issues were noted with the update for Individual #154. For example, the SLP identified that the SAP for pointing was not effective and recommended discontinuing it. However, the SLP did not recommend a replacement for this SAP. Moreover, the EC assessment that was identified as necessary at the time of the comprehensive assessment, still was not done for the update, and no assessment was offered of the individual's AAC needs or potential. The therapist had two opportunities to address Individual #154's potential for rehabilitation, and both times chose not to address the individual's significant decline.

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: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual,	13% 1/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	1/1

	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.										
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/6	N/A	N/A	0/1	0/1	0/1	0/1	0/1	N/A	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	36% 4/11	N/A	0/1	3/3	0/3	0/1	1/1	0/1	N/A	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A

Comments: a. At the time of the document production, Individual #142's ISP had not been finalized, so it was not submitted. For the remaining eight individuals, the ISP document could not be used to gain a clear understanding of how the individual communicated and/or how others should communicate with the individual. Based on the State's comments on the draft report, Center SLPs need to review descriptions in individuals' ISPs from the perspective of whether a lay person unfamiliar with the individual would gain a good understanding of how the individual uses speech or other communication, and how the individual best receives communication. For example, this should go beyond stating that an individual "uses speech" to communicate. When an individual uses an AAC device (e.g., Individual #112), SLPs should write such descriptions so that lay members of the team understand when and how the individual uses the device, and how to interact with the individual when using the device.

b. Simply including a stock statement such as "Team reviewed and approved the Communication Dictionary" did not provide evidence of what the IDT reviewed, revised, and/or approved.

c. Individual #154 had a significant change of status, but her ISP/ISPAs did not include revised strategies to address her communication. Similarly, Individual #353 experienced a significant change of status, but his ISP was not revised to reflect needed changes in communication strategies and interventions.

In its comments on the draft report, the State disputed the negative finding for Individual #348, and argued that "This individual does not have any AAC/EC supports," and therefore, the score should be N/A. The State then pointed to the Living Options discussion of his ISP. It read in part: "Use a total communication approach with [Individual #348]. When you interact with him, use speech, gestures and sign language throughout his daily routine. Throughout [Individual #348's] daily routine, look for situations in which basic sign language can be incorporated with interactions with others… To increase [Individual #348's] expressive sign vocabulary, encourage him to sign with you in addition gesturing [sic]… If [his] behaviors are controlled, it is felt that he has the capacity to expand his communication skills through use of simple signs and pictures." The State's argument was flawed from a number of perspectives, for example: 1) the information included about Individual #348's communication strategies in the Living Option discussion should have been included elsewhere in the ISP as well; and 2) the excerpt the State highlighted clearly identified strategies that ISP action plans should have addressed through either staff support objectives and/or skill acquisition programs, but review of the ISP action plans

revealed no such action steps. Clearly, for this individual, the score of 0 remained correct.

d. Individual #154's SLP did not develop and implement therapy interventions to address the individual's significant decline. In its comments on the draft report, the State disputed this finding. The State indicated: "For individual 154, and [sic] ISPA was held on 5/1/17 to discuss the comprehensive assessment and recommended SAP, which was approved. Referenced in document TX-SA-1802-II.81. [Individual #154] page 3. If reference to no ISPA being held following the ISP, communication supports did not need to be put into place again because once the individual became psychiatrically stable she returned to baseline and was communicating verbally. Direct speech therapy was not implemented because her decline was related to her psychiatric diagnoses and psychiatric medication changes that could not be rehabilitated by a speech pathologist. An alternative communication method of pointing was recommended based on the individual's level of functioning and strengths at the time of the comprehensive assessment. Once she became stable psychiatrically, she returned to baseline and communication supports were not necessary." However, based on the documentation the Center submitted, including the update and ISP, Individual #154 had not returned to baseline. In May, the IDT documented she was agitated and that the SAP was best for her. They did not report data related to this SAP gathered between April and June, but rather stated they heard her say juice when making a choice, but the SLP documented no other information to justify that she no longer required the pointing SAP, and no alternative was offered. Psychiatric changes might also justify therapeutic intervention for cognition, problem-solving, etc. If the IDT discontinued the SAP because she got better, then they should have held an ISPA meeting to address this and identify carry over or other guidelines for continued communication. The Center submitted no ISPA or IPN that stated she recovered to baseline, and in its comments on the draft report, the State referenced no such documentation.

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: Performance remained about the same as at the last review, which means that indicator 3 sustained high performance and, therefore, will be moved to the category of requiring less oversight. About two-thirds of the SAPs were practical, functional, and meaningful. Improvements in the ISP development process should lead to concurrent improvements in this indicator, too. It was good to see reliable data were collected for many (about two-thirds) of the SAPs. This has only been seen in one or two other Centers. Note that all of the SAPs for one individual (Individual #184) met criteria for all indicators. Indicators 4 and 5 will remain in active oversight.

#	Indicator	Overall Score	Individuals: 125	274	290	191	114	100	354	207	184
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.	100%	2/2	2/2	3/3	3/3	3/3	3/3	3/3	2/2	2/2

		23/23									
4	SAPs are practical, functional, and meaningful.	65% 15/23	2/2	2/2	0/3	2/3	2/3	1/3	3/3	1/2	2/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	65% 15/23	1/2	1/2	3/3	2/3	2/3	3/3	0/3	1/2	2/2

Comments:
All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. There were two SAPs available to review for Individual #125, Individual #274, Individual #207, and Individual #184, for a total of 23 SAPs for this review.

3. It was encouraging to see that all of SAPs were measurable and based on assessment results.

4. Several SAPs were judged not to be practical or functional because they did not appear to be consistent with the individual's vision statement in their ISP (e.g., Individual #100's vocational SAP of filling a jig).

5. The majority of SAPs had SAP integrity measures. Several, however, did not include the IOA portion of the integrity measure and were, therefore, scored as 0.

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: All three indicators showed lower performance than at the last review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 125	274	290	191	114	100	354	207	184
10	The individual has a current FSA, PSI, and vocational assessment.	56% 5/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1

Comments:
10. Individual #354 and Individual #184 did not have current and complete vocational assessments. Individual #207's PSI was not updated since his return to the facility, and Individual #191 did not have a PSI.

11. Only Individual #125's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.

12. Individual #184 and Individual #191's vocational assessments did not have recommendations for SAPs.

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, 20 of these indicators were in the category of requiring less oversight. For this review, two other indicators were added to this category, in restraints and dental.

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

The Monitoring Team attended morning unit meetings for all three units and met with the unit directors. They were knowledgeable about their units, facility operations, and staffing needs. Morning unit meetings contained a lot of relevant information about the past day and the upcoming day.

Goals/Objectives and Review of Progress

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

Graphic displays summarizing behavioral health/PBSP data did not meet criteria (after having improved to 100% at the last review). Similarly, data were not presented at psychiatric clinic. Peer review and progress notes, however, continued to be at criteria.

Acute Illnesses/Occurrences

Regarding frequent usage of restraints, most of the requirements to address the various variables around frequent restraint were occurring and meeting criteria, that is, all but indicator 20. This individual accounted for about one-third of the crisis intervention restraints over the nine-month review period (and up to 75 percent of the restraints in some recent months), so it seems important to make sure that all of the various variables are thoroughly reviewed and considered for making treatment changes.

Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected.

Implementation of Plans

As noted in the last report, numerous problems were identified with regard to the provision of medical care. Unfortunately, during this review, improvements generally were not noted. 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 include:

- 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 five 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.
- PCPs often did not write IPNs explaining the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there was a need for referral to the IDT.

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

Based on medication administration observations, the majority of nurses observed did not follow infection control practices, and did not follow the individuals' PNMPs. For two of the four medication administration observations, State Office staff and the Compliance Nurse appropriately required immediate retraining of the nurses involved. Significant work is needed to ensure that individuals at San Antonio SSLC receive medications safely.

Individuals reviewed had teeth extractions only when restorative options were exhausted. As a result, the related indicator will move to less oversight. Individuals reviewed also had fluoride applications according to their needs. However, the Center should focus on ensuring individuals receive, as needed, prophylaxis care, tooth brushing instruction, dental x-rays, and restorative work.

For the individuals reviewed, the Clinical Pharmacist had completed timely QDRRs, and the quality of the QDRRs had improved. However, it was of significant concern that when prescribers agreed to recommendations for the individuals reviewed,

documentation often was not presented to show they implemented them, or prescribers offered no response to the recommendations.

Based on observations, there were numerous instances (73% of 52 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.

The psychiatrists reported a very good working relationship with the behavioral health services department and, moreover, numerous staff and managers around campus talked positively about the psychiatrists' presence, availability, and willingness to be active members of the IDT.

In behavioral health services, given the absence of good, reliable data, progress could not be determined for all of the individuals. Given the critical role of reliable data in applied behavior analysis, it is vital that San Antonio SSLC address the problems in the current PBSP data system immediately.

Based on the Center's data that were available, three individuals met one or more target behavior objectives, but they were never updated. Four individuals were not making progress, however, modifications were made to their programs and were implemented.

The majority of individuals had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing their PBSPs were trained on the its implementation.

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: These indicators applied to one individual in the review group. Continued progress was seen. For instance, indicator 25 showed sustained high performance and will be moved to the category of requiring less oversight. Performance for indicators 21 and 22 improved and, if sustained after the next review, both might be moved to this category, too, after the next review. Some additional attention to the requirements of indicator 20 should bring that indicator up to criteria, too. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall	184								

		Score									
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/1	0/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 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% 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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.										
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 1/1	1/1								
26	The PBSP was complete.	N/A	N/A								
27	The crisis intervention plan was complete.										
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.	
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	

Comments:
This outcome and its indicators applied to Individual #184.

20. Individual #184's ISPAs following more than three restraints in 30 days reflected a discussion of her psychiatric issues and potential side effects of her medications that could affect her target behaviors that provoke restraints. The ISPA documented medication changes to address those issues. No discussion, however, of adaptive skills, or medical issues that might affect her restraints was documented.

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: As noted for outcome 2, good progress was occurring in the development of psychiatry-related goals. Once more complete, progress can be determined and indicators 8 and 9 can be scored. Even so, when an individual was deteriorating or was having worsening psychiatric condition, actions were taken by the psychiatrist and IDT, and these actions were implemented. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184

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.	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
8-9. Without measurable goals and objectives, progress could not be determined, however, there was documentation that Individual #290 was experiencing psychiatric stability, which was good to see.

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 (e.g., medication adjustments, consultation with medical specialists, and alterations to non-pharmacological interventions) were developed and implemented. This was the case for all individuals in the review group with the exception of Individual #290. There was documentation in the psychiatry notes describing Individual #290 as experiencing psychiatric stability; as such, revisions to her treatment plan were not needed.

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

Summary: The psychiatrists reported a very good working relationship with the behavioral health services department and, moreover, numerous staff and managers around campus talked positively about the psychiatrists' presence, availability, and willingness to be active members of the IDT. The paperwork requirements that evidence some of this are needed for criteria to be met for these indicators in the future. Both will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
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.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/7	0/1	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1

Comments:
23. There was a need for improvement with regard to psychiatric documentation referencing the behavioral health target behaviors as well as the psychiatric symptoms for monitoring. When reviewing the psychiatric clinical documentation, it was noted that different

psychiatric indicators and behavioral health target behaviors were noted throughout the same document.

24. There was no documentation or indication that the psychiatric provider participated in the development of the PBSP for the seven individuals who had a PBSP.

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

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 125	274	290	191	114	100	354	207	184
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	50% 3/6	N/A	0/1	0/1	0/1	1/1	1/1	N/A	N/A	1/1
26	Frequency was at least annual.	40% 2/5	N/A	0/1	0/1	0/1	1/1	1/1	N/A	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	17% 1/6	N/A	0/1	0/1	0/1	0/1	0/1	N/A	N/A	1/1

Comments:
25 and 27. These indicators applied to six of the individuals. This facility had a functioning neuro-psychiatry clinic that included a neurologist and psychiatrist as well as other IDT members. As such, collaboration regularly occurred. There was a need for improvement with regard to the documentation of the psychiatric participation. In the records, the primary care physician documented the psychiatrist's participation. Review of the psychiatric documentation did not reveal references to the plan or actions to be taken in five of the six cases. This was discussed with the psychiatric providers during the monitoring visit, specifically the need for them to document their participation and collaboration with neurology clinic.

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. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. Attention to the content of the documentation of the reviews is needed as well as various aspects of the psychiatry clinic sessions. All three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 125	274	290	191	114	100	354	207	184
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%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
35	The individual's psychiatric clinic, as observed, included the standard components.	0% 0/5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
33. Quarterly reviews were generally completed in a timely manner.

34. The Monitoring Team looks for nine components of the quarterly review. None of the examples included all the necessary components. The evaluations were missing five to eight of the required elements.

35. During the monitoring visit, psychiatry clinics were observed for five individuals (Individual #305, Individual #108, Individual #92, Individual #53, Individual #145). There were challenges noted in the psychiatry clinics as data were generally regarding behavioral challenges not psychiatric symptoms or indicators. The development of psychiatric indicators for individuals was discussed with the treating psychiatrists during the monitoring visit.

In the examples observed during the monitoring visit, medication adjustments were made in the absence of symptom data and generally in response to anecdotal information. In addition, individuals did not regularly participate in the psychiatry clinic. One of the individuals, Individual #92, was knocking on the clinic door and requesting to be admitted so that he could participate. Unfortunately, the treatment team had already completed their discussion of his case, in the absence of his participation.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: Frequency and prescriber review were not occurring as required. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
36	A MOSES & DISCUS/AIMS 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. There were delays in both assessments and the prescriber review of the assessments. For example, regarding Individual #125, the AIMS assessment was performed in February 2017 and August 2017. There should have been assessments performed in May 2017 and November 2017. In another example, regarding Individual #184, the AIMS dated 8/16/17 was not reviewed by the provider until 11/27/17 and the MOSES dated 8/16/17 was not reviewed by the provider until 11/7/17.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: Emergency interim clinics were available for all individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184

37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 4/4	N/A	1/1	N/A	1/1	N/A	N/A	N/A	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	75% 3/4	N/A	1/1	N/A	0/1	N/A	N/A	N/A	1/1	1/1

Comments:
37. Emergency clinics were available for all individuals.

38-39. There was documentation of emergency/interim clinics regarding four individuals. In the example regarding Individual #191, there was documentation of a clinical encounter to discuss behavioral challenges. At the time of the clinic, it was noted that medication adjustments were made, but there was no notation that the individual was evaluated at the time. This was an issue that was discussed with the psychiatry staff during the monitoring visit, specifically that individuals should be evaluated when making medication adjustments and should participate in the clinical encounters.

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	125	274	290	191	114	100	354	207	184
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

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

Summary: Most of the individuals for whom their medication regimen met the criteria for polypharmacy had a tapering plan in place. None, however, had a written empirical justification for the regimen. Half of the individuals were reviewed by polypharmacy committee as per the criteria for indicator 46. These

Individuals:

three indicators will remain in active monitoring.											
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	0% 0/6	0/1	0/1	N/A	0/1	N/A	N/A	0/1	0/1	0/1
45	There is a tapering plan, or rationale for why not.	83% 5/6	0/1	1/1	N/A	1/1	N/A	N/A	1/1	1/1	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	50% 3/6	1/1	0/1	N/A	0/1	N/A	N/A	1/1	0/1	1/1

Comments:
44. These indicators applied to six individuals. Polypharmacy justification was not appropriately documented in any of the examples.

45. There was documentation for five of the six individuals showing a plan to taper various psychotropic medications or documentation of why this was not being considered.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for three individuals in the review group meeting criteria for polypharmacy. The polypharmacy committee meeting was observed during the visit. There was a need for improvement with regarding to the review and justification of the regimens. This meeting should be a brisk discussion of the regimens with the psychiatrist presenting the justification of polypharmacy for critique.

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. Even so, based on these data that were available, three individuals met one or more target behavior objectives, but they were never updated. Four individuals were not making progress, however, modifications were made to their programs and were implemented. The indicators in this outcome will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
6	The individual is making expected progress	0%	0/1	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1

		0/7									
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/3	N/A	N/A	0/1	0/1	N/A	N/A	N/A	0/1	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 4/4	N/A	N/A	1/1	1/1	N/A	N/A	1/1	N/A	1/1
9	Activity and/or revisions to treatment were implemented.	100% 4/4	N/A	N/A	1/1	1/1	N/A	N/A	1/1	N/A	1/1

Comments:
6. Individual #290, Individual #191, Individual #354, and Individual #184's PBSP data indicated that they were not progressing. Individual #125, Individual #114 and Individual #207's PBSP 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 #290 achieved her inappropriate social behavior objective in July 2017, however, it was not updated as of December 2017. Similarly, Individual #191's aggression, ISB, and elopement objectives were achieved in November 2017, however, they were not updated as of December 2017. Finally, Individual #207 achieved his verbal aggression and refusals objectives in December 2017, however, they were not updated as of January 2018.

8-9. Individual #290, Individual #191, Individual #354, and Individual #184's progress notes included actions to address their lack of behavioral progress for some of their target behaviors, 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: Performance remained about the same as during previous reviews. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 125	274	290	191	114	100	354	207	184
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.	71% 5/7	0/1	N/A	1/1	1/1	1/1	N/A	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 the its implementation. Individual #125 and Individual #207 were the exceptions.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: Graphic displays summarizing behavioral health/PBSP data did not meet criteria (after having improved to 100% at the last review). Similarly, data were not presented at psychiatric clinic. This needs to be corrected in order for indicator 21 to remain in the category of requiring less oversight after the next review. Peer review and progress notes, however, continued to be at criteria. Indicator 20 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
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.	14% 1/7	0/1	N/A	0/1	0/1	1/1	N/A	0/1	0/1	0/1
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. The usefulness of Individual #125, Individual #290, Individual #191, Individual #354, Individual #207, and Individual #184's graphs to encourage data based decisions was diminished by them not including indications of the occurrence of important environmental changes (e.g., medication changes).

21. In order to score this indicator, the Monitoring Team observed Individual #125's psychiatric clinic. Although the behavior analyst had recent graphed data at the meeting, it was not shared with the team members. Sharing graphs with the IDT allows team members to see behavioral treads and encourages data based decisions.

Outcome 8 – Data are collected correctly and reliably.											
Summary: Given the critical role of reliable data in applied behavior analysis, it is vital that San Antonio SSLC address the problems in the current PBSP data system immediately. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	125	274	290	191	114	100	354	207	184

		Score									
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/7	0/1	N/A	0/1	0/1	0/1	N/A	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.	0% 0/7	0/1	N/A	0/1	0/1	0/1	N/A	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% 0/7	0/1	N/A	0/1	0/1	0/1	N/A	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% 7/7	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/7	0/1	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1

Comments:
26-27. The data collection system for all individual's target and replacement behaviors utilized a system where staff were only required to record data once a shift. This system does not encourage regular, timely, data collection and would not likely provide an adequate measurement of behaviors that occur at high rates.

28. There were established measures of IOA and treatment integrity. There was not, however, an adequate measure of data collection timeliness.

29. There were established frequency and minimal levels of IOA, data collection timeliness, and treatment integrity for all individuals' 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 was not adequately measured (see indicators 5 and 28), this indicator was scored 0. Given the critical role of reliable data in applied behavior analysis, it is vital that San Antonio SSLC address the problems in the current PBSP data system immediately.

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	207	114	136	112	154	256	353	142	348
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant	6%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2

	and achievable to measure the efficacy of interventions.	1/18									
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/1
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 #207 – aspiration, and diabetes; Individual #114 – other: cataracts, and other: macrocytosis; Individual #136 – seizures, and other: chronic kidney disease; Individual #112 – diabetes, and osteopenia; Individual #154 – constipation/bowel obstruction, and cardiac disease; Individual #256 – diabetes, and cardiac disease; Individual #353 – osteoporosis, and GI problems; Individual #142 – diabetes, and polypharmacy/medication side effects; and Individual #348 – cardiac constipation/bowel obstruction, and seizures).

The goal/objective that was clinically relevant, as well as measurable was for Individual #348 – seizures. 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: Individual #142 – diabetes.

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

Outcome 4 – Individuals receive preventative care.

Summary: For only one of the nine individuals reviewed, documentation was present to show they received the preventative care they needed. Since the last review, regression was seen in the overall scores related to preventative care. Although, some improvement was noted, the Center also needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	Individual receives timely preventative care:										

	i. Immunizations	56% 5/9	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1
	ii. Colorectal cancer screening	0% 0/5	N/A	0/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A
	iii. Breast cancer screening	0% 0/2	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	56% 5/9	1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1
	vi. Osteoporosis	43% 3/7	N/A	1/1	0/1	0/1	0/1	0/1	1/1	1/1	N/A
	vii. Cervical cancer screening	0% 0/3	N/A	N/A	0/1	0/1	0/1	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	56% 5/9	0/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1

Comments: a. It was concerning that only one of the nine individuals reviewed received the necessary preventative care and/or had documentation to show it was completed. The following provide examples of problems noted:

- For Individual #207, the official immunization records did not document his varicella status.
- For Individual #114, the Center did not provide documentation of a C-scope that reportedly was completed in 2008, but rather stated it showed only hemorrhoids.
- In April 2017, Individual #136 had a negative fecal immunochemical test (FIT). However, given the lack of documentation of family history, it was not clear that this individual was in the "average risk" category for which FIT is acceptable. The IDT had contact with her sister who visited a couple times a year, so obtaining a family history was possible. In addition, in 2016, she was due for a pap smear and gynecological exam. Fibroid cysts were found on the ultrasound. The AMA only stated that risk/benefit did not warrant more invasive testing. More explanation was needed.
- For Individual #112:
    - In response to a request for a hearing screen, the Center submitted a document that stated: "no data to submit."
    - On 2/5/15, she had a CT BMD that showed the lumbar spine with osteopenia trending towards osteoporosis. The recommendation was to repeat the test in two years, but documentation was not submitted to show this occurred.
    - On 2/20/15, she had a Pap smear, which was negative. The recommendation was to repeat in three years, but documentation was not submitted to show this occurred.
    - The date of her last mammogram was unknown.
    - The official immunization records did not document her varicella status.
    - On 4/12/17, she had a negative FIT. However, given the lack of documentation of family history, it was not clear that

this individual was in the "average risk" category for which FIT is acceptable.

- For Individual #154:
  - On 7/2/14, the IDT held an ISPA meeting, and discontinued Pap smears, mammograms, and DEXA scans for this 44-year-old due to "behavioral abnormality." The IDT did not provide clinical justification for discontinuing these important preventative tests.
  - The official immunization records did not document her varicella status.
  - In response to a request for a hearing screen, the Center submitted a document that stated: "no data to submit."
- For Individual #256:
  - On 6/7/12, he had a colonoscopy that showed a tubular adenoma. Of significant concern, no documentation was submitted to show the completion of the repeat colonoscopy that should have been completed in five years.
  - In response to a request for a hearing screen, the Center submitted a document that stated: "no data to submit."
  - In February 2015, he had a CT BMD that showed the L5 vertebra with osteopenia to osteoporosis with increased the fracture risk. The test should have been repeated in two years, but documentation was not submitted to show this occurred.
- For Individual #353, the official immunization records did not document his varicella status. In addition, although the AMA indicated he had a colonoscopy in 2010, the Center did not submit the report.
  - For Individual #348, in response to a request for a hearing screen, the Center submitted a document that stated: "no data to submit."

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. It was good to see that for some individuals, PCPs had done this, but improvements continue to be needed.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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.	N/A									
Comments: None.											

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	Individuals:

accepted standards of care, and for some individuals reviewed, significant concerns were noted. For the past four 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.											
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	22% 2/9	0/2	N/A	0/2	1/2	N/A	1/2	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.	11% 1/9	0/2		0/2	1/2		0/2		0/1	
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	80% 4/5	1/1	N/A	N/A	N/A	1/1	N/A	1/2	N/A	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	67% 2/3	1/1				N/A		0/1		1/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	40% 2/5	0/1				1/1		1/2		0/1
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.	75% 3/4	1/1				1/1		1/1		0/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	0% 0/5	0/1				0/1		0/2		0/1

Comments: a. For five of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses addressed at the Center, including: Individual #207 (laceration on 9/13/17, and hypotension on 10/3/17), Individual #136 [upper respiratory infection (URI) on 12/27/17, and URI on 9/25/17], Individual #112 (dermatitis on 9/18/17, and dermatitis on 10/31/17), Individual #256 (bronchitis on 9/10/17, and hematoma on 12/17/17), and Individual #142 (allergic rhinitis on 8/10/17).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #112 (dermatitis on 10/31/17), and Individual #256 (bronchitis on 9/10/17).

b. For Individual #112 (dermatitis on 10/31/17), 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.

The following provide examples of concerns noted:

- On 9/13/17, the PCP documented that Individual #207 was assessed after being hit in the head with a salt shaker and sustaining a laceration to the forehead. The individual reported a mild headache. The PCP's entire physical exam was: "right forehead with 1.5cm laceration with small amount of swelling, closed with adhesive." The assessment/plan read: "laceration cleaned, bleeding stopped, taped, nursing to monitor, f/u if fails to heal. Tylenol given." Nursing staff implemented neurological checks. On 9/18/17, nursing staff documented that the wound was closed. Given that the injury was considered serious enough to implement neurological checks, the PCP should have completed and documented a thorough exam of the head, including pupillary responses. The PCP also should have completed a neurologic exam. Moreover, the PCP did not describe the details of the wound (e.g., the shape, such as linear, jagged, etc., and depth of the wound). Additionally, the PCP did not document the plan for wound care.
- On 10/3/17, nursing staff documented that Individual #207 experienced two falls the previous day at the day program. It was noted that his gait appeared off. Nursing staff also documented that the "QIDP also spoke to PCP today and PCP has some concerns with gait, unsteadiness and overall appearance." The note indicated that the PCP ordered labs, and home staff were asked to keep an eye on him.

  On 10/3/17, the PCP noted that since May 2017, the individual was being assessed due to unsteadiness, generalized malaise, and a 10-pound weight loss. Individual #207 reported feeling off balance and nauseated. The only documentation for the physical exam was that of the head and neck (HEENT). The assessment was malaise. The PCP ordered labs and a chest x-ray and indicated follow-up would occur the next morning. An addendum, dated 10/4/17, noted that the case was discussed in the morning report and with psychiatry. The labs and chest x-ray were normal, but affect and behavior were different. The psychiatrist was to see Individual #207 the next day, and on 10/10/17, the IDT planned to complete a "root cause analysis" (RCA). No documentation was found to show that the PCP actually re-assessed the individual.

  On 10/4/17, nursing staff documented that the individual appeared lethargic and slow to respond to questions. He reported feeling dizzy. The initial blood pressure reading was 96/62 with a heart rate of 63. The repeat blood pressure reading was 86/48 with a pulse of 70. The plan was to await lab results. It was unclear when nursing staff notified the PCP of these findings.

On 10/5/17, the psychiatrist evaluated Individual #207, noted that Topamax could be causing sedation and weight loss, and recommended a computed tomography scan (CT) of the head.

On 10/6/17, nursing staff notified the Medical Director that the individual fell and was complaining of feeling dizzy. A note indicated: "PCP discussed about individual having scheduled ct scan on Monday, MD still wants individual to be monitored for hypotension."

On 10/9/17, nursing staff continued to document that Individual #207 was weak and lethargic, and in bed most of the weekend. On 10/9/17, the CT of head was negative; and the CT of the lumbar spine showed degenerative and spondylotic changes, spondylolisthesis, and chronic appearing pars fractures L4/5 and L5s1.

On 10/10/17, the PCP documented in an IPN that Individual #207 was being transferred to the ED for evaluation of weakness, and an 11-pound weight loss since September. The differential diagnosis was based on an incomplete physical exam (as documented).

- On 12/27/17, Individual #136's PCP documented receipt of a call on 12/25/17 to report that the individual had a high fever and green nasal discharge. The PCP ordered a flu screen, which was negative. The diagnosis was rhinosinusitis and the plan was to treat with Tylenol and saline nasal spray for five days. The PCP's IPN note documented that the individual was not examined and no documentation of a medical assessment was found in the records.
- On 9/18/17, Individual #112's PCP documented: "Notified this a.m. of face/neck rash of uncertain duration." The physical exam showed a patchy, slightly scaly erythematous rash to the lower face and upper neck without exudate or blisters. The assessment was a rash of uncertain duration. The PCP documented that if the rash was infectious, it likely was fungal versus bacterial. The plan was to start fluconazole pending review with pharmacy of other medications. On 9/29/ 17, the PCP documented an addendum that stated the rash was resolved, and fluconazole ended. There was no documentation of a consultation with the Clinical Pharmacist regarding the use of fluconazole. The IMR, dated 11/17/17, noted the individual was treated with fluconazole 100 mg per gastrostomy tube for 10 days.
- On 10/31/17, Individual #112's PCP documented: "notified in the am of left neck rash of uncertain duration. The physical exam revealed a patchy erythematous non-raised non-discreet rash to the lower left lateral neck. There was no break in the skin and there was no discharge. She had a similar rash in similar location in the past." The assessment was intermittent mild fungal rash. The plan was to apply a topical antifungal cream for one week. On 11/9/17, the PCP documented that the rash was reduced, but persisted after using an antifungal powder for one week. The exam showed an erythematous rash around the trach stoma with no skin "disintegrity." The assessment was rash partly responding to topical treatment. The plan was to start oral fluconazole.

On 11/9/17, nursing staff documented emailing the PCP about a pharmacy recommendation regarding Vitamin D and also about a dermatology consult, which was ordered on 11/30/16, that needed to be scheduled.

On 11/16/17, the PCP documented: "given the repeated skin infection in the same location, am obtaining a dermatology consult." On 11/21/17, the PCP documented being notified that no dermatology consult request was found. In an addendum on 11/28/17, the PCP indicated that the consult was re-ordered.

On 11/25/17, another PCP evaluated the individual. The assessment was chafing associated with the trach straps and the plan was to apply Desitin as a barrier. The records reviewed did not include a dermatology consult note.

- On 9/10/17, Individual #256's PCP evaluated him for reports of a mild fever the prior evening. The individual's sister also wanted an evaluation due to coughing. The individual accidentally hit his head as he was entering the dining room. The physical exam revealed a 1 centimeter (cm) abrasion to the left brow. The lungs were clear to auscultation and the neurologic exam was grossly intact. The assessment was "possible URI, suspect viral." The plan was to monitor for further fever, consider the need for a chest x-ray, if warranted, and continue antihistamines for allergic rhinitis. The PCP also documented that the individual experienced "Mild head trauma – not serious."

  On 9/13/17, the PCP documented that Individual #256 was re-examined the previous day as he stayed in bed all day. A slight cough was reported. No fever was reported to the PCP, but documentation showed the individual was on the fever protocol. The physical exam was pertinent for mild rhonchi with no wheezing or rales. The chest x-ray showed peri-bronchial thickening consistent with bronchitis. Zithromax was prescribed. No follow-up was documented on 9/14/17.

  On 9/19/17, the PCP wrote an antibiotic course completion note, in which the PCP documented that the acute bronchitis resolved as evidenced by reduction of cough. However, the PCP did not document reexamination of the individual.

  On 9/24/17, another PCP documented notification that the individual had a cough, but was not examined as he was out on pass. On 9/25/17, nursing documented that the individual's sister was requesting follow-up of the cough. Nursing staff documented that the Medical Director evaluated the individual at home, and reported the lungs were clear, but the Medical Director did not document an assessment in the records.
- On 12/17/17, nursing staff documented the presence of a 6 cm by 4 cm bruise to Individual #256's left flank. The individual's sister was concerned about this finding and requested an evaluation. On 12/18/18, the PCP noted a 5 cm diameter bruise over the left inferior ribs. A mild hematoma was palpated under the skin. The assessment was hematoma and ecchymosis of the left flank. The plan was to "monitor per routine protocol." The PCP's exam appeared incomplete. For example, it was not clear if the individual's ribs were tender, crepitus was palpated, or if the injury included the costovertebral area. The PCP did not conduct and/or document any follow-up for this injury of unknown etiology.

c. For four of the nine individuals reviewed, the Monitoring Team reviewed five acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #207 (pneumonia on 10/10/17), Individual #154 (humeral fracture), Individual #353 (stoma site drainage on 9/9/17, and pneumonia on 10/23/17), and Individual #348 (left thigh abscess on 8/13/17).

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

- As noted above, on 10/10/17, the PCP documented in an IPN that Individual #207 was being transferred to the ED for evaluation of weakness, and an 11-pound weight loss since September. On 10/15/17, Individual #207 returned to the Center from the hospital, and on 10/16/17, the PCP saw him. The PCP documented that he was admitted with pneumonia and had a negative chest x-ray. The initial portable chest x-ray was negative. However, the next day, a follow-up x-ray showed an increase in interstitial markings. The Modified Barium Swallow Study (MBSS) showed penetration of thin liquids. The PCP's

assessment was an 11-pound weight loss and movement disorder. There was no plan to address the abnormal chest x-ray and swallow study. A pulmonary consult was requested. On 10/18/17, the PCP saw the individual again. The PCP did not address the relationship between the flash penetration of thin liquids seen on the MBSS and the perihilar infiltrates. The PCP documented in the interval medical review (IMR) that the Pneumonia Review Committee considered this bronchitis. It should be noted that bilateral perihilar infiltrates on a chest x-ray are not consistent with the diagnosis of bronchitis.

- On 7/15/17, nursing staff documented that at approximately 11:45 a.m., Individual #154 was noted to have swelling and deformity to the right elbow. The PCP was notified and requested an x-ray. At approximately 1:05 p.m., nursing staff contacted the PCP to request additional pain medications and report that radiology confirmed a fracture of the elbow. The PCP ordered transfer to the ED. On 7/15/17, the PCP documented that the individual was transferred to the ED for evaluation of a comminuted elbow fracture. The origin of the injury was unknown.

  On 7/16/17, the PCP documented that Individual #154 returned from the ED and was seen at approximately 5:00 p.m. The diagnosis was comminuted fracture of the right distal humerus, fracture of the right clavicle, and fracture and compressed lumbar vertebrae. The PCP ordered Norco for pain control. On 7/17/17, the PCP documented the results of labs, including a complete blood count (CBC) and electrolytes. It was noted that there was a drop in hemoglobin of approximately one gram. The albumin was low at 2.6. The plan was to have a discussion with the dietitian. The PCP did not document an assessment to determine the neurovascular status of the injured upper extremity. In its comments on the draft report, the State indicated: "The IPN dated 7-17-17 for individual #154 states, 'R arm in splint to mid-hand. The distal hand was puffy appearing with 1+ edema and sl [slight] ecchymosis generally. All extremities warm. Radial pulse not examinable for visit.'" The physical examination related to injuries of the extremities must include documentation of an assessment of neurovascular status. The radial pulse may not have been accessible; however, there was an opportunity to assess capillary refill in the digits.
- On 9/9/17, nursing staff documented that Individual #353's G-tube stoma area was red, tender, and inflamed. The individual was uncomfortable when placement verification was done. Nursing staff contacted the PCP to report the assessment, and to ask for pro re nata (PRN, or "as needed) pain control. The PCP gave an order for Tylenol "pending evaluation for possible cellulitis today." On 9/10/17, the PCP documented that the individual was transferred to the ED on 9/9/17, for reports of redness, tenderness, and purulent drainage at the stoma site. The individual also had an elevated blood pressure and heart rate. In the afternoon, Individual #353 returned from the ED after having G-tube placement again confirmed and suspected abscess ruled out. The assessment was peri-stomal cellulitis and the plan was to prescribe Augmentin for seven days. There was no additional documentation by a medical provider for this individual who was prescribed a seven-day course of antibiotics for an infectious process.
- On 10/23/17, at 7:48 p.m., Individual #353's PCP documented morning notification that the individual had congested lungs. At the time, nursing staff notified the PCP of normal vital signs. The PCP indicated that a physical exam was conducted in the morning, revealing chest bilateral crackles, and no acute distress. The assessment was congestion versus pneumonia. The PCP indicated that the individual was at high-risk for both community acquired pneumonia and aspiration. The PCP ordered an x-ray and flu swab. The x-ray showed bilateral patchy pneumonia. The diagnosis was presumptive pneumonia. The plan was to transfer the individual to the ED. There was no documentation of an assessment in the morning. This note was written at 7:48 p.m., and the individual was transferred at 5:47 p.m. He was admitted to Intensive Care Unite (ICU) with aspiration pneumonia and sepsis. Per the hospital history and physical, the symptoms started on Friday, 10/20/17. It was stated that he was noted to be less active with more discomfort. The Center did not submit any IPNs related to the development of the illness. During

this period, the first documentation of illness was on 10/23/17.

On 11/21/17, Individual #353 returned from the hospital, and the PCP saw him on 11/21/17. This post-hospital assessment included two pages of computer generated vital signs, but very little information on the actual hospitalization. There was no documentation that the individual was admitted into ICU with aspiration pneumonia and severe sepsis (as documented in hospital notes). The plan focused on the use of aspirin in an individual with a history of a gastrointestinal. bleed. The only plan related to the diagnosis of recurrent aspiration pneumonia was to follow the individual for swallowing and mobility.

On 11/22/17, another PCP saw Individual #353 and wrote a thorough post-hospital note and documented an appropriate physical examination and plan of care. However, there was no additional follow-up for this individual with a prolonged hospitalization and multiple medical problems. The next PCP entry was made on 11/30/17, and it was related to respiratory symptoms. On 12/6/17, the individual was sent back to the ED for evaluation of hypoxia and was admitted again with acute respiratory failure and intubated.

- On 8/3/17, nursing staff documented that Individual #348 was found on the floor. Redness was noted to the right lower back and left buttocks. The PCP was notified and indicated the individual would be seen. However, no physician evaluated the individual. Over a period of several days, nursing staff documented problems with impaired skin integrity. On 8/12/17, nursing staff documented that another PCP was called with the results of a CBC. The PCP indicated "not viral cont [continue] to hydrate if get worse through the night to call". The PCP had been notified earlier of a temperature of 101.1.

  On 8/13/17, the PCP made an IPN entry stating that a call was received from nursing staff the prior evening, because the individual had a fever, had not been out of bed all day, and had not eaten the entire day. Orders were given for Tylenol, fluids and a CBC. On the morning of the evaluation, the individual ate, showered, but returned to bed. The exam documented lungs clear to auscultation, abdomen with bowel sounds and soft, and heart with regular rate and rhythm. The white blood cell count (WBC) was 7.8. The assessment was fever, unspecified appears viral. A repeat CBC was ordered. The plan was to follow-up the next morning, on 8/14/17.

  The PCP never specified the reported temperature. The physical exam was largely incomplete. There was no documentation of an examination of the head and neck, which would be important in assessing fever and a potential viral syndrome. There was no documentation of the skin to note if any exanthems or rashes were present.

  On 8/15/17, the PCP documented that the individual was still not himself. Again, the physical exam was incomplete: "disheveled difficult to get off the couch, but ambulates well when this was ultimately achieved; rhinorrhea; abd [abdomen] soft; no breathing difficulties." The assessment was "nonspecific complaints with change in behavior. CBC, shower and breakfast. Will follow up on labs later today." An addendum late that day noted the individual was out of bed, with a temperature of 99 and WBC of 5.5. There was no follow-up, even though the diagnosis was not clear.

  On 8/18/17, the PCP wrote a note documenting the individual was being transferred to the ED for evaluation, because he appeared ashen and ill and was becoming hypotensive. According to the ED records, the individual was brought to the ED with left anterior thigh area with pain swelling and erythema. He had recently been discharged from the hospital with right knee

cellulitis. For this admission, he was diagnosed with left thigh cellulitis. The CT scan showed a fluid collection in the left hip. The individual was taken to the operating room for incision and drainage of a left hip abscess.

The assessments the PCP conducted never documented any examination of the extremities. As noted above, the physical exam upon his arrival to the ED clearly indicated an infection in the left thigh/hip area.

On 8/28/17, Individual #348 returned to the Center, and the PCP assessed him. The plan was to continue daily wound care with sedation and pain control. On 8/29/17, a PCP/provider did not see him, but on 8/30/17, another PCP saw him. The next PCP entry was on 9/1/17, and it was the AMA. The AMA submitted in the IPN section was not complete.

On 9/12/17, the PCP documented that Individual #348 was discharged from the hospital's wound clinic and was returning to his regular home.

On 8/ 24/17, the IDT held an ISPA meeting, but did not discuss how this significant infection and abnormal physical exam were not detected at the Center.

In its comments on the draft report, the State disputed these findings, and stated: "On 8-3-17, individual #348 fell/slid from a chair and developed an abrasion on his right flank and had redness on his left buttock and both knees. On 8-4-18, nursing charted that the right sided abrasion was healing with no signs or symptoms of infection. After the initial request for PCP evaluation, it is noted that MD would be notified if there was a reason for intervention but the abrasion healed. Nursing had resolved the skin issue of right sided abrasion. To attribute an abscess that was found by CT on the left hip near the bursa of the greater trochanter to an abrasion on the right flank is clinically incongruent."

The Monitoring Team's intent was not to demonstrate causality between the abrasion and the abscess. The Monitoring Team documented this finding as historical information, as well as to underscore the concern that a PCP never evaluated the individual's skin issues. The concern regarding the diagnosis of cellulitis and abscess was the failure to document any abnormality of the left thigh at the Center. As documented, the assessments the PCP completed on 8/12/17, 8/13/17, 8/15/17, and 8/18/17, included either no physical exam or an incomplete exam for an individual who was ill with no clear etiology. Moreover, in the 8/18/17 evaluation, the PCP noted that the individual was "hypotensive," yet made the decision to transfer the individual to the ED by state vehicle. The diagnosis of cellulitis was made upon arrival to the ED with the ED physician noting "left anterior thigh and groin area with pain, swelling, erythema." It is difficult to ascertain how the ED physician documented an abnormal exam consistent with cellulitis shortly after the individual left the Center. The PCP assessment done just prior to transfer did not include any assessment consistent with cellulitis of the thigh. The CT was obtained after admission, and on 8/22/17, surgery occurred.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.	
Summary: PCPs often did not write IPNs explaining the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there was a need for referral to the IDT.	Individuals:

These indicators will continue in active oversight.											
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	85% 11/13	1/2	1/1	2/2	1/1	2/2	1/1	2/2	N/A	1/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	85% 11/13	1/2	1/1	2/2	1/1	2/2	1/1	2/2		1/2
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.	15% 2/13	0/2	1/1	0/2	0/1	0/2	0/1	0/2		1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	86% 6/7	1/1	1/1	1/1	1/1	1/1	0/1	N/A		1/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/11	0/2	N/A	0/2	0/1	0/2	0/1	0/2		0/1

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 13 consultations. The consultations reviewed included those for Individual #207 for pulmonary on 10/20/17, and neurology in October 2017 (specific date unknown); Individual #114 for neurology on 9/26/17; Individual #136 for renal on 8/21/17, and eye on 9/14/17; Individual #112 for eye on 9/14/17; Individual #154 for orthopedics on 9/19/17, and gastroenterology (GI) on 10/30/17; Individual #256 for eye on 9/19/17; Individual #353 for pulmonary on 12/1/17, and pulmonary on 9/22/17; and Individual #348 for epileptology on 11/28/17, and podiatry on 11/9/17.

a. through c. San Antonio SSLC was not using the same process for reviewing consultations as most other Centers. Generally, Centers are using the IPNs to document the PCP's review of the consultations, and their agreement or disagreement with recommendations. At San Antonio SSLC, it appeared that a stamp was applied to the consultation report, PCPs or other providers indicated agreement of disagreement with recommendations, and then, LVNs scanned the consultations into the system. Although this practice technically met the requirements for Indicators a and b, the IPNs State Office policy requires that PCPs write IPNs so that IDTs have an easy way of understanding the consultations, and next steps. For most consultations reviewed, PCPs had not written the required IPNs.

Also, of note, at times, the Medical Director wrote IPNs for consultations (e.g., neurology clinic), but it was unclear that the PCP responsible for the individual's care reviewed the consultation and/or that it meaningfully impacted care. Except in cases where waiting for the PCP to review and process the consultation would negatively impact care (e.g., assigned PCP is on vacation and consultation report arrives, consultation results require immediate action and PCP is unavailable), the assigned PCP should take the lead role in reviewing the consultation recommendations, making decisions about implementation, and implementing the agreed-upon recommendations.

d. When PCPs agreed with consultation recommendations, evidence generally was submitted to show orders were written for all relevant recommendations, including follow-up appointments. For Individual #256 for eye on 9/19/17, the recommendations on the consultations were illegible, and the Monitoring Team was unable to determine whether or not the PCP agreed or disagreed.

e. Without IPNs, it often was not possible to determine whether or not IDTs should have been involved in reviewing recommendations, and developing ISPAs to document decisions and plans.

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

Comments: Significant work is needed to ensure that for individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care are completed, and the PCP identifies the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 207	114	136	112	154	256	353	142	348
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	22% 4/18	0/2	2/2	0/2	0/2	0/2	1/2	1/2	0/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #207 – aspiration, and diabetes; Individual #114 – other: cataracts, and other: macrocytosis; Individual #136 – seizures, and other: chronic kidney disease; Individual #112 – diabetes, and osteopenia; Individual #154 – constipation/bowel obstruction, and cardiac disease; Individual #256 – diabetes, and cardiac disease; Individual #353 – osteoporosis, and GI problems; Individual #142 – diabetes, and polypharmacy/medication side effects; and Individual #348 – cardiac constipation/bowel obstruction, and seizures).

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 #114 – other: cataracts, and other: macrocytosis; Individual #256 – diabetes; and Individual #353 – GI problems. The following provide examples of concerns noted:

- On 10/15/17, Individual #207 returned to the Center from the hospital, and on 10/16/17, the PCP saw him. The PCP documented that he was admitted with pneumonia and had a negative chest x-ray. The initial portable chest x-ray was negative. However, the next day, a follow-up x-ray showed an increase in interstitial markings. The Modified Barium Swallow Study (MBSS) showed penetration of thin liquids. The PCP's assessment was an 11-pound weight loss and movement disorder. There was no plan to address the abnormal chest x-ray and swallow study. On 10/16/17, a standard chest x-ray (erect posterior and lateral views) showed infiltrates in the bilateral perihilar regions with enlargement of the heart. Again, on 10/17/17, the PCP saw the individual who noted that the individual's cough continued. A pulmonary consult was requested. On 10/18/17, the PCP saw the individual again.

  The PCP did not address the relationship between the flash penetration of thin liquids seen on the MBSS and the perihilar

infiltrates that were documented on the EPA and lateral chest x-ray. The PCP documented in the interval medical review (IMR) that the Pneumonia Review Committee considered this bronchitis. It should be noted that bilateral perihilar infiltrates on a chest x-ray is not consistent with the diagnosis of bronchitis.

In its comments on the draft report, the State disputed these findings, and stated: When Individual #207 was in the hospital, the etiology of his symptoms was thought to be secondary to tardive dyskinesia. Speech Therapy evaluation showed adequate oral pharyngeal phase and noted penetration with no aspiration and a protective response present… The chest x-ray was not consistent with aspiration. He was evaluated by Pulmonology after his return to the SASSLC. The pulmonologist questioned the diagnosis of pneumonia… On the Interval Medical Review, the reviewer's reference to bronchitis comes from a radiologist's report of 10-27-17 that describes resolved perihilar infiltrates and resolving bronchitis. Bronchitis was not the PCP's interpretation."

The Monitoring Team's comments were in reference to the two x-rays obtained during the individual's hospitalization that ended on 10/15/17. On 10/10/17, the radiologist noted: "A single frontal view of the chest demonstrates no active cardiopulmonary disease. Consider follow-up PA and lateral chest for a better evaluation." On 10/11/17, the radiologist wrote "low lung volumes with bibasilar bronchovascular crowding. Increased perihilar and inferior perihilar interstitial markings are noted." The radiologist did not indicate that the diagnosis was bronchitis. The PCP documented two x-rays in the interim medical review. The first stated chest x-ray (CXR) perihilar infiltrate (10/16/17). The second comment was "CXR resolved perihilar infiltrates resolving bronchitis." The PCP provided no date for this second result. The Monitoring Team did not have access to the radiographic reports, and relied on the description the PCP provided in the documentation. Again, the radiologist reported an increase in interstitial markings for the second hospital x-ray. The PCP actually documented the presence of perihilar infiltrates on the CXR in the IMR. The presence of pulmonary infiltrates and increased interstitial marking should be evaluated within the context of an individual who had an MBSS that showed flash penetration of thin liquids.

- Individual #207's AMA did not document a weight, waist circumference, or body mass index (BMI). The assessment section documented that the individual was overweight, and nutritional support and Topiramate would continue. The PCP should have included a specific plan regarding the prescribed diet.

  The IMR, dated 11/9/17, documented that the individual's weight increased from 161 to 176 pounds. The Estimated Desired Weight Range (EDWR) was 122 to 150 pounds. The PCP did not address this weight gain. It should be noted that both the individual's father and mother had diabetes mellitus. The mother had coronary artery disease (CAD) [status post (S/P) angioplasty) and the father had hyperlipidemia. This individual had increased risk for development of diabetes mellitus and the PCP should have addressed this risk.
- With regard to Individual #136's seizure disorder, the summary/plan section of the AMA noted: continue current medication, and neurological follow-up every two years. The current status section of the AMA appeared to indicate that she had been seizure-free since 1982. There was no documentation of the justification of the need to continue an anti-epileptic drug (AED). The date of the last neurology consult was not known.
- Individual #136's PCP provided little information in the assessments on the progressive nature of her chronic kidney disease. This individual had a Glomerular filtration rate (GFR) of 35, and there was no discussion regarding the progressive nature of the disease and the eventual need for renal replacement therapy. The AMA only stated continue current care and follow-up

with nephrology. The IDT should be made aware of the interventions that are necessary to slow progression to renal failure [e.g., avoid non-steroidal anti-inflammatory drugs (NSAIDs), proton pump inhibitors (PPIs), dietary restrictions).

- Individual #112's AMA, dated 8/21/17, indicated she had a Vitamin D deficiency. The PCP's assessment/plan was "history of vitamin d deficiency - continue current dose of vitamin d. If next value high [sic] will decrease D." On 7/5/17, the individual had a Vitamin D level of 102, but there was no change in therapy. This level was documented in the August QDRR with no comments on the potential adverse outcomes associated with supra-therapeutic levels of Vitamin D.

  On 10/13/17, the Clinical Pharmacist documented a pharmacy clinical intervention stating: "noted vitamin D results over 100 - on ergocalciferol solution 10,000 units per day. As this is a fat-soluble vitamin, I recommended decreasing the dose to 3000 units per day and rechecking the vitamin D level in six months." At the time of the Monitoring Team's review in February 2018, the prescriber response to this recommendation was pending. The PCP did not make an IPN entry related to this recommendation.

  On 11/9/17, nursing staff documented that the PCP was emailed about the pharmacy recommendation regarding a decrease in the daily dose of vitamin D. On 11/13/17, nursing staff documented that in reference to the clinical intervention recommendation on 10/13/17, the PCP changed the order for the ergocalciferol, effective 11/11/17.
- Individual #154 was treated with three medications for constipation. The AMA did not include constipation in the "Summary/Plans" section. Therefore, the PCP had not addressed non-pharmacologic measures. Similarly, for Individual #348, the PCP prescribed two medications for constipation, but did not list constipation as an active problem in the AMA.
- According to the AMA, Individual #154's hypercholesterolemia/low high-density lipoprotein (HDL) was well controlled on fish oil and simvastatin. Her plan included: "lipid profile yearly and medication changes as needed." The exact indication for starting the statin was not documented, so it was not clear that the PCP followed the American College of Cardiology/American Heart Association (ACC/AHA) guidelines. Similarly, the PCP for Individual #256 did not document the utilization of the ACC/AHA guidelines in prescribing a moderate intensity status to address his cardiac risk.
- For Individual #142, the PCP made no comments on the risk of metabolic syndrome other than stating that the QDRR was reviewed, and the risk was moderate. Even though the individual's BMI was over 30, the PCP did not list obesity as a problem; therefore, there was no plan to address it. Individual #142 was also a smoker and had a sedentary lifestyle.
- For Individual #142, the PCP's comment on medication related to anemia and thrombocytopenia stated that the QDRR was reviewed, but the PCP offered no substantive comments on the individual's weight gain, medication use, increased triglycerides (TGs) and other adverse effects of medication use. Moreover, the prescribers did not review the AIMS in a timely manner.
- Individual #348 received four AEDs. However, the AMA, dated 9/1/17, gave no indication of how well the individual's seizure disorder was controlled. The assessment/plan simply stated: seizure disorder (myoclonic, tonic-clonic). There was no plan for management. No IMRs were submitted. On 11/28/17, the neurologist saw the individual. The Medical Director, as opposed to the PCP, wrote the IPN in follow-up to the consult, and noted that seizures occurred in January, April and July. The individual was also a rapid metabolizer, so higher drug dosages were required. The seizure control was considered "good," and follow-up was scheduled in six months.

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. However, in some cases, documentation was 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 Score	207	114	136	112	154	256	353	142	348
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	38% 5/13	0/2	N/A	2/2	0/2	0/1	N/A	2/2	0/2	1/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed were implemented for: Individual #136 – seizures, and other: chronic kidney disease; Individual #353 – osteoporosis, and GI problems; and Individual #348 – seizures.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: a. and b. The documentation the Center submitted was insufficient to assess these indicators. The Monitoring Team will work with State Office on a solution.											

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: It was good to see that the Clinical Pharmacist completed timely QDRRs for the individuals reviewed. If the Center sustains this performance, Indicator a might move to the category of less oversight at the time of the next review. It was	Individuals:

also positive that the quality of the QDRRs had improved. However, it was of significant concern that when prescribers agreed to recommendations for the individuals reviewed, documentation often was not presented to show they implemented them, or prescribers offered no response to the recommendations. All of these indicators will remain in active oversight.											
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	94% 17/18	2/2	2/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100% 8/8	N/A	2/2	N/A	N/A	2/2	N/A	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.	94% 17/18	2/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	83% 10/12	2/2	2/2	N/A	N/A	2/2	1/2	N/A	2/2	1/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	0% 0/13	0/1	0/1	0/1	0/2	0/2	0/2	0/1	0/1	0/2
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: b. Individual #112's QDRR, dated 8/23/17, did not comment on the high Vitamin D level of 102.

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

d. When prescribers agreed to recommendations for the individuals reviewed, documentation often was not presented to show they implemented them. Often, prescribers offered no response to the recommendations. This was of significant concern.

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.

#	Indicator	Overall Score	Individuals: 207	114	136	112	154	256	353	142	348
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1
c.	Monthly 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 dental goal(s)/objective(s); and	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, 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 #353 was edentulous, but was part of the core group, so a full review was conducted. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings. In addition, Individual #112 had a low risk rating, but had Type III periodontal disease and required suction tooth brushing. Her dental risk rating should have been at least medium. None of the individuals reviewed 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, integrated progress reports on existing goals with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. 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: N/A			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not rated (N/R)	N/R	N/R	N/R	N/R	N/R	N/R	N/A	N/R	N/R
Comments: Individual #353 was edentulous. 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 implemented a process to ensure inter-rater reliability with the Centers.											

Outcome 5 – Individuals receive necessary dental treatment.											
Comments: Given that during past reviews and this review, individuals reviewed had extractions only when restorative options were exhausted (Round 9 – 100%, Rounds 10 and 11 – N/A, Round 12 – 100%, and Round 13 - 100%), Indicator f will move to the category requiring less oversight. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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.	63% 5/8	1/1	1/1	0/1	1/1	0/1	1/1	N/A	1/1	0/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	75% 6/8	1/1	1/1	1/1	1/1	0/1	1/1		1/1	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.	63% 5/8	1/1	0/1	1/1	0/1	1/1	1/1		0/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 3/3	1/1	1/1	1/1	N/A	N/A	N/A		N/A	N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	67% 2/3	N/A	1/1	N/A	N/A	0/1	N/A		N/A	1/1
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A		N/A	1/1

Comments: Individual #353 was edentulous.

a. Individual #136 received treatment with TIVA approximately annually (e.g., on 12/13/16, and 10/23/17). However, in 2016, she had Type III periodontal disease that progressed in 2017 to Type IV periodontal disease. She should have prophylactic care more often, but there was no evidence that her IDT had developed a plan, weighed the risks and benefits of more frequent TIVA, and/or identified and implemented other supports that might assist her to tolerate the needed care.

On 12/12/17, Individual #154 had treatment under TIVA. It was the only time during 2017 that she received prophylactic care. Again, she had Type IV periodontal disease, but her IDT had not developed a plan, weighed the risks and benefits of more frequent TIVA, and/or identified and implemented other supports that might assist her to tolerate the needed care.

Although the Dentist indicated Individual #348 had Type II periodontal disease, available data showed that he actually had Type III periodontal disease. He only had prophylactic care once in 2017 (i.e., in May). Again, the IDT had not developed a plan, weighed the risks and benefits of more frequent TIVA, and/or identified and implemented other supports that might assist him to tolerate the needed care.

e. In January 2017, Individual #154 lost a crown, but it was not until December 2017 that it was replaced. Given that this likely caused the individual pain and/or sensitivity, it should have been addressed sooner.

Outcome 7 – Individuals receive timely, complete emergency dental care.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.										
b.	If the dental emergency requires dental treatment, the treatment is provided.											
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.											
Comments: a. through c. N/A												

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A

	suction tooth brushing.										
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/1				0/1					
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/1				0/1					
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/1				0/1					
Comments: a. through d. The documentation the Center submitted was for administration of chlorohexidine "swish and spit." There was no documentation of nursing staff performing the suction tooth brushing.											

Outcome 9 – Individuals who need them have dentures.											
Summary: Over the past two reviews, improvements were noted with regard to the dentist's assessment of the need for dentures for individuals with missing teeth. If the Center sustains this progress, Indicator a might move to the category of less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. For the individuals reviewed with missing teeth, the Dental Department provided justification for not recommending 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: Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
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%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									

Comments: a. through f. Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected.

The Monitoring Team has discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should work with State Office to correct this issue.

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

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

Individuals:

#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	measure the efficacy of interventions.	0/18									
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 #207 – respiratory compromise, and weight; Individual #114 – polypharmacy/side effects, and aspiration; Individual #136 – aspiration, and circulatory; Individual #112 – GI problems, and respiratory compromise; Individual #154 – dental, and fractures; Individual #256 – choking, and osteoporosis; Individual #353 – infections, and seizures; Individual #142 – falls, and skin integrity; and Individual #348 – constipation/bowel obstruction, and infections). None of the goals/objectives reviewed were clinically relevant, achievable, and/or measurable.

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

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

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

#	Indicator	Overall Score	Individuals: 207	114	136	112	154	256	353	142	348
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/8	0/1	0/1	N/A	N/A	0/1	N/A	0/2	0/1	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs 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: Based on medication administration observations, the majority of nurses observed did not follow infection control practices, and did not follow the individuals' PNMPs. For two of the four medication administration observations, State Office staff and the Compliance Nurse appropriately required immediate retraining of the nurses involved. Significant work is needed to ensure that individuals at San Antonio SSLC receive medications safely. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 207	114	136	112	154	256	353	142	348
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R									
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 4/4	1/1	N/A	N/A	1/1	1/1	1/1	N/A	N/A	N/A
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									
	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	0% 0/4	0/1	N/A	N/A	0/1	0/1	N/A	0/1	N/A	N/A

	enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.										
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	33% 1/3	N/A			0/1	0/1	1/1			
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	50% 2/4	1/1			0/1	0/1	1/1			
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of four individuals, including Individual #207, Individual #112, Individual #154, and Individual #256.

d. The following provide examples of concerns noted:

- After Individual #207 returned from the hospital with a diagnosis of pneumonia, his IDT did not develop or modify an IHCP related to aspiration/choking.
- During Individual #112's medication administration observation, the medication nurse only auscultated anterior breath sounds, but not posterior breath sounds. The Center's nurse auditor identified the problem, and pulled the medication nurse for additional training.
- During the observation of Individual #154's medication administration, the medication nurse did not follow current standards of care. More specifically, the nurse attempted to listen to the individual's lung sounds while reaching over the medication

room half-door. The State Office observer identified the issue, and the medication nurse was pulled for re-training. In addition, in December 2016, Individual #154 had aspiration pneumonia, and a new Diagnosis of dysphagia. The IHCP intervention related to respiratory stated: "Eval for new resp symptoms during Eating, Drinking, Medication Administration." The IHCP did not include specific interventions for nurses to check lung sounds prior to or post medication administration.

- For Individual #353, a Change of Status (COS) IRRF, dated 8/15/17, indicated he had been hospitalized, and included one nursing assessment that read: "N-Assess lung sounds q shift." However, the IHCP included no intervention for assessing lung sounds before and after medication administration.

f. Neither Individual #112 nor Individual #154's PNMPs to which the medication nurses had access had been updated.

g. For Individual #112, the medication nurse did not follow infection control procedures for the stethoscope and G-tube procedures. Similarly, for Individual #154, the medication nurse did not use proper procedures for infection control in relation to the stethoscope.

Physical and Nutritional Management

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

Summary: The IDTs of most individuals reviewed that met criteria for PNMT involvement made referrals, but mechanisms are still needed to ensure that when IDTs do not make necessary referrals, the PNMT makes a self-referral. Overall, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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% 0/13	0/2	0/1	0/1	0/2	0/1	0/2	0/1	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	8% 1/13	0/2	0/1	0/1	0/2	0/1	0/2	0/1	0/1	1/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/13	0/2	0/1	0/1	0/2	0/1	0/2	0/1	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/13	0/2	0/1	0/1	0/2	0/1	0/2	0/1	0/1	0/2

	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/13	0/2	0/1	0/1	0/2	0/1	0/2	0/1	0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	75% 3/4	N/A	1/1	N/A	N/A	0/1	N/A	1/1	1/1	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6		0/1	0/1		0/2		0/1	0/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6		0/1	0/1		0/2		0/1	0/1	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6		0/1	0/1		0/2		0/1	0/1	
	v. Individual has made progress on his/her goal/objective; and	0% 0/6		0/1	0/1		0/2		0/1	0/1	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6		0/1	0/1		0/2		0/1	0/1	

Comments: The Monitoring Team reviewed 13 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: choking, and falls for Individual #207; weight for Individual #114; aspiration for Individual #136; aspiration, and fractures for Individual #112; aspiration for Individual #154; choking, and falls for Individual #256; falls for Individual #353; weight for Individual #142; and choking, and falls for Individual #348.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. 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: falls for Individual #348.

b.i. The Monitoring Team reviewed six areas of need for five individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: falls for Individual #114; weight for Individual #136; weight, and fractures for Individual #154; aspiration for Individual #353; and falls for Individual #142.

Individual #136 had been referred to the PNMT in October 2016, and remained on their caseload.

On 12/27/16, Individual #154's IDT referred her to the PNMT for weight loss. On 1/31/17, the PNMT completed an assessment, and on 8/4/17, the PNMT discharged her. In December 2016, she had aspiration pneumonia, but the January 2017 PNMT assessment did not fully address this diagnosis. In addition, on 7/15/17, Individual #154 experienced three fractures, including fractures to her right

clavicle, compressed lumbar vertebra, and a comminuted right distal humerus fracture. Because the clavicle and humerus are long bones, she met criteria for referral to the PNMT. The fracture of her spine also was a qualifying condition that required referral. The PNMT should have at least reviewed the circumstances related to these fractures.

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

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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% 0/19	0/2	0/2	0/2	0/2	0/3	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.	13% 1/8	0/1	0/1	N/A	N/A	0/3	N/A	1/2	0/1	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/3	N/A	0/1	0/1	N/A	0/1	N/A	N/A	N/A	N/A

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

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

- According to documentation the Center provided, on 8/16/17, 9/15/17, 10/2/17, and 10/3/17, Individual #207 fell. On 10/10/17, he was hospitalized for generalized weakness, malaise, numbness to his bilateral lower extremities, weight loss, and drooling. Upon his return, he required direct PT services to increase his ability to walk. His IDT had previously rated him at low risk for falls, and the IDT did not change this rating in response to the change in status. Therefore, he had no IHCP related to falls, even on a temporary basis.
- In addition to a lack of PNMT review/assessment to address Individual #154's multiple fractures, no evidence was found to show that the IDT revised the IRRF or IHCP.

- According to the OT/PT assessment and ISPAs, Individual #353's IDT saw increased instability; an increased number of falls, including one during which he hit his head; and increased agitation and self-injurious behavior. However, the OT/PT did not conduct an assessment.

c. The following problems were noted:

- For Individual #114, the PNMT conducted a review and made recommendations. No evidence was found of an ISPA meeting in which the PNMT discussed the recommendations and effectiveness of the interventions with the IDT, and/or that the IDT modified the IHCP as a result.
- Since October 2016, Individual #136 had been on the PNMT caseload, and on 8/29/17, the PNMT discharged her. Although the PNMT met with the IDT to review the actions taken, the PNMT did not clearly outline what the IDT needed to do moving forward. Such action steps could have resulted in modification to the IHCP addressing her weight.
- On 9/8/17, Individual #154's IDT and PNMT held an ISPA meeting. The information documented provided little clarity regarding what the problem with her weight had been, what the PNMT did to address it, and/or what the IDT needed to do moving forward.

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. These indicators will remain in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	27% 14/52	
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.	Not Rated.	
Comments: a. Comments: a. The Monitoring Team conducted 52 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during six out of 25 observations (24%). Staff followed individuals' dining plans during seven out of 26 mealtime observations (27%). Staff completed transfers correctly during one out of one 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: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
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: a. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, for the individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	7% 1/15	1/1	0/1	0/1	0/1	0/6	N/A	0/4	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/15	0/1	0/1	0/1	0/1	0/6		0/4	0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/15	0/1	0/1	0/1	0/1	0/6		0/4	0/1	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/15	0/1	0/1	0/1	0/1	0/6		0/4	0/1	
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/15	0/1	0/1	0/1	0/1	0/6		0/4	0/1	
Comments: a. and b. Individual #256 had functional skills, had participated in direct PT in the previous ISP year, and met his goals at that time. He was part of the outcome group, so the Monitoring Team completed a limited review. Individual #348 did not require a goal/objective, but he did have needs addressed through OT/PT supports. A full review was completed for him. The goal/objective that was clinically relevant, but not measurable was the walking goal for Individual #207.											

Although Individual #353's goals/objectives for direct therapy were measurable, they were not included in the ISP or incorporated through an ISPA.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, integrated progress reports with data and analysis of the data were generally not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

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	207	114	136	112	154	256	353	142	348
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/5	0/1	N/A	N/A	N/A	0/3	N/A	0/1	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/5	0/1	N/A	N/A	N/A	0/3	N/A	0/1	N/A	N/A

Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented.

b. Although the PT wrote a discharge summary for Individual #207's direct therapy, the IDT did not meet to discuss and approve the decision.

For Individual #154, the OT wrote a discharge summary for the direct therapy related to her upper extremity fracture. Although on 9/21/17, the IDT held an ISPA meeting, the IDT did not define the transition to a SAP or home program. The ISPA merely stated that Individual #154 would have a home exercise program to improve the function of both of her arms. The IDT did not define a goal, or make the support measurable. In addition, for Individual #154's OT intervention related to her hand, and her direct PT, it was difficult to determine the status (e.g., no mention in QIDP monthly summaries, no ISPA, no discharge summary).

For Individual #353's direct PT, the QIDP integrated reviews did not include data, and no ISPAs were found showing the support had been discontinued.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: This indicator will remain in active oversight. During future reviews, it will be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.			Individuals:								
#	Indicator	Overall	305	145	108	233	127	345	190	335	78

		Score									
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.	N/R	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
		Individuals:									
#	Indicator		206								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1								

Comments: c. The Monitoring Team did not complete a full set of observations related to proper fit, so this indicator has not been rated. However, based on limited observations, a number of concerns were noted. The Monitoring Team has provided information about the individuals observed for whom fit was an issue to facilitate the correction of potential problems.

Based on observation of Individual #305, Individual #145, Individual #108, Individual #233, Individual #127, Individual #345, Individual #190, Individual #335, Individual #78, and Individual # 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, four indicators were in the category of requiring less oversight. At this review, no other indicators will be moved to this category and one indicator, in communication, will be returned to active monitoring.

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.

A lot of work went into the development of the ISPs, however, implementation and data collection were poor. Across the set of ISPs in the review group, one goal had enough data to determine progress (it was progressing). The others were not making progress (based upon Center report) and, for none, were actions taken based on this absence of progress.

Overall, direct support staff were generally able to describe individual's health and behavioral risks.

Regarding SAP progress, there was improvement in all four; data were available and used for making treatment decisions for about half of the SAPs. One of the SAPs was found to be fully complete, but the majority of SAP components were found in all of the SAPs. Efforts initiated around the time of the last review were showing some evidence in the high percentage of SAPs that were implemented correctly. Along these lines, more SAPs had a schedule of the assessment of integrity/quality (e.g., direct observation).

San Antonio SSLC continued to attend to engagement in activities (e.g., measurement, activity development, feedback to staff). Management staff should ensure that self-scoring is not artificially, unintentionally, inflated. Generally, the facility's engagement scores were substantially higher than the Monitoring Team's engagement scores. In order for the facility to improve engagement, it is critical that they first have a reliable measure of engagement.

For the applicable individual reviewed, the IDT did not have a way to measure a clinically relevant outcome(s) related to dental refusals.

Overall, IDTs did not have a way to measure clinically relevant, achievable, and measurable outcomes related to individuals' formal communication services and supports.

Based on the Monitoring Team's observations to determine if individuals were using their AAC devices functionally, the Center regressed with regard to ensuring the devices were readily accessible to the individuals. The related indicator will return to

active oversight. The Center also should focus on ensuring that staff prompt individuals to use their AAC devices in a functional manner, and that when individuals use them, staff respond.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: One goal had enough data to determine progress (it was progressing). The others were not making progress (based upon Center report) and for none were actions taken. A lot of work went into the development of the ISPs, however, implementation and data collection were poor. Implementation and data are required if this set of indicators is to be able to meet criteria. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	191	114	100	207	154	142			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/5	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	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. For personal goals that did not meet criterion as described above, there was no basis for assessing progress in these areas. For 18 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 (i.e., indicator 3).

For the one goal where valid data were available, Individual #100 was making progress towards learning to set the table.

See Outcome 7, Indicator 37, for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

QIDPs acknowledged that lack of implementation data was a problem and were developing a plan to address this facility wide.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	191	114	100	207	154	142			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/5	0/1	0/1	0/1	N/A	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. Overall, direct support staff were generally able to describe individual's health and behavioral risks. Staff, however, were not fully implementing ISPs, so it was difficult to verify that they could exhibit competence in implementing support plans. ISPs rarely included detailed instructions to guide staff when implementing the ISP.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report. IDTs need to monitor the implementation of all action plans and address barriers to implementation.

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: There was improvement in all four indicators with all of them, for the most part, scoring higher than at any review to date. That being said, scores were still very low for SAPs progressing, and for actions taken when there was no progress (indicators 6 and 8). For those SAPs that the Center determined were met, however, actions were taken in most cases. Further, data were available and used for making treatment decisions for about half of the SAPs. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
6	The individual is progressing on his/her SAPS	10% 2/21	0/2	1/2	0/3	0/3	0/1	1/3	0/3	0/2	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	86% 6/7	0/1	1/1	2/2	N/A	N/A	1/1	1/1	1/1	N/A
8	If the individual was not making progress, actions were taken.	10% 2/10	1/1	1/1	0/1	0/3	N/A	N/A	0/1	0/1	0/2
9	Decisions to continue, discontinue, or modify SAPs were data based.	55% 11/20	1/2	2/2	2/3	0/3	N/A	3/3	2/3	1/2	0/2

Comments:
6. Individual #274's sort clothes SAP and Individual #100's set the table SAPs were scored as improving. Overall, however, 43% of the SAPs demonstrated improvement. Most of those SAPs, however, were scored as 0 because indicator #5 found they either did not have interobserver agreement (IOA) and, therefore, their data were not demonstrated as reliable (e.g., Individual #125's clean the sidewalk SAP), or indicator 4 found them not be practical or functional (Individual #290's identify numbers SAP). Individual #114's pay for his purchases and play an instrument SAPs were not rated for this indicator because they were rated as having reliable data (indicator 5) and as practical and functional (indicator 4), however, there were insufficient data to assess progress. Finally, other SAPs may have been progressing, however, were scored as not progressing because the graphs did not clearly show improvement by not reflecting when steps were progressed or levels of prompting were reduced (see indicator 17).

7-8. Six of seven SAP objectives that were achieved were moved to the next step (e.g., Individual #274 achieved step 1 of her sort clothes SAP in October 2017, and began step 2 in November 2017). The exception was Individual #125's clean the sidewalk SAP, which was achieved in August 2017, however, continued through December 2017.

The majority of SAPs that were not progressing, however, did not identify action to address the lack of progress (e.g., Individual #191's shaving SAP). The exceptions were Individual #274's record activities SAP which had documentation that the SAP would reworded due to lack of progress, and Individual #125's read a recipe SAP which had documentation that new materials would be provided to the staff due to lack of progress.

9. Overall, there appeared to be data-based decisions to continue, discontinue, or modify SAPs in 55% of the SAPs. This represents a substantial improvement from the last review, and reflects an improvement in the management of SAPs at San Antonio SSLC.

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

Summary: Progress was seen, moving towards meeting criteria. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 125	274	290	191	114	100	354	207	184
13	The individual's SAPs are complete.	4% 1/23	1/2	0/2	0/3	0/3	0/3	0/3	0/3	0/2	0/2

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although only one of the SAPs was found to be complete, the majority of SAP components were found in all of the SAPs.

The majority of the SAPs were using the new SAP format. The old SAP format applied to Individual #290's three SAPs and Individual #100's set table and brush teeth SAPs. The comments below apply to the New Format SAPs.

Individual #125's clean the sidewalk SAP was a single step task and was judged to be complete. A SAP book located in each residence indicated each individual's current training step and a copy of the SAP training instructions. The instructions for the all of the multiple

step SAPs also directed staff to assist the individual to complete all remaining steps in the task analysis (e.g., Individual #354's turn on the TV SAP).

The instructions did not, however, indicate how staff should respond and score if an earlier mastered step now required prompting. Additionally, some of the SAPs (e.g., Individual #184's identify numbers SAP) did not represent chains of behavior, but rather gradual increases in the difficulty of the task. These tasks, therefore, may be best taught if the individual is only exposed to subsequent steps after mastery of earlier (i.e., easier) steps.

Ensuring that individuals are motivated to complete SAPs is a critical training component and, therefore it is important that efforts are made to ensure that potent reinforcers are provided following the successful completion of all SAPs. This individualization of reinforcement for correct SAP completion was apparent in several SAPs (e.g., Individual #354's dressing SAP where correct responses were to be followed by tactile praise, and the opportunity to go sit in the living room). Other SAPs, however, merely included saying "good job," which may not a potent reinforcer for every individual (e.g., Individual #100's fill a jig SAP).

Finally, for the majority of SAPs, only one trial per training session was practical (e.g., Individual #274's sort clothes SAP). For others, however, multiple trials were possible and may increase the rate of acquisition of the skill (e.g., Individual #191's sign outside) and, therefore, the number of trials per session should be included in the training instructions.

Outcome 5- SAPs are implemented with integrity.

Summary: The efforts initiated around the time of the last review were showing some evidence in the high percentage of SAPs that were implemented correctly. Along these lines, more SAPs had a schedule of the assessment of integrity/quality (e.g., direct observation). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
14	SAPs are implemented as written.	80% 4/5	N/A	1/1	N/A	N/A	N/A	N/A	1/1	2/2	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.	65% 15/23	1/2	1/2	3/3	2/3	2/3	3/3	0/3	1/2	2/2

Comments:

14. The Monitoring Team observed the implementation of five SAPs: Individual #207's laundry and seal a bag SAPs, Individual #354's use a picture board, and Individual #274's sort clothes SAP were judged to be implemented with integrity. Individual #184's identify numbers SAP, however, was not implemented as written. This 80% score represents a dramatic improvement in the quality of SAPs at San Antonio SSLC.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. San Antonio SSLC regularly conducted 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 15 of the SAPs achieved this frequency and level of SAP integrity. As discussed in indicator 5, several more SAPs had integrity measures, however, they did not include IOA measures.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
16	There is evidence that SAPs are reviewed monthly.	39% 9/23	0/2	0/2	3/3	0/3	3/3	0/3	3/3	0/2	0/2
17	SAP outcomes are graphed.	0% 0/23	0/2	0/2	0/3	0/3	0/3	0/3	0/3	0/2	0/2

Comments:
16. The majority of SAPs were reviewed in QIDP monthly reports. However, in many reviews, only one month of SAP data were presented, which did not allow data-based decisions concerning the need to continue, discontinue, or modify them (e.g., Individual #207 seal the bag SAP).

17. All the SAPs were graphed. They were scored as 0 because, as discussed in indicator 6, they were generally not useful in displaying SAP progress because they did not reflect progress of steps or decreasing prompt levels (e.g., Individual #274's record activities SAP, Individual #290's wash clothes SAP).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: San Antonio SSLC continued to attend to engagement in activities (e.g., measurement, activity development, feedback to staff). Management staff should ensure that self-scoring is not artificially, unintentionally, inflated. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	125	274	290	191	114	100	354	207	184
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and	89%	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1

	treatment sites are achieved.	8/9									

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found three (Individual #274, Individual #290, Individual #191) to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

21. San Antonio SSLC tracked engagement in all residences 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 for December 2017 indicated that 89% of the residential and day treatment sites of the individuals achieved their goal level of engagement.

That being said, generally, the facility's engagement scores were substantially higher than the Monitoring Team's engagement scores (also compare to indicator 18 above). In order for the facility to improve engagement, it is critical that they first have a reliable measure of engagement.

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. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 125	274	290	191	114	100	354	207	184
22	For the individual, goal frequencies of community recreational activities are established and achieved.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
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 #125, Individual #274, Individual #191, Individual #114, Individual #100, Individual #207, and Individual #184 achieved their community outing goals.

It was encouraging to see an increase in the percentage of individuals that achieved their community recreational outing goals.

There was not a goal for SAP training in the community for any individuals. 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:											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.										
Summary: For the applicable individual reviewed, the IDT did not have a way to measure a clinically relevant outcome related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/1						0/1			
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1						0/1			
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1						0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1						0/1			
Comments: a. through e. Individual #256's IDT had not developed a goal/objective to address his 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: Overall, IDTs did not have a way to measure clinically relevant, achievable, and measurable outcomes related to individuals' formal communication services and supports. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	207	114	136	112	154	256	353	142	348
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/11	N/A	0/1	0/3	0/3	0/1	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	27% 3/11		0/1	3/3	0/3	0/1	0/1	0/1		0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/11		0/1	0/3	0/3	0/1	0/1	0/1		0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/11		0/1	0/3	0/3	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% 0/11		0/1	0/3	0/3	0/1	0/1	0/1		0/1

Comments: a. and b. Individual #207 and Individual #142 had functional communication skills, so formal communication supports or services were unnecessary.

The following provide a few examples of problems noted:

- Individual #112's SLP included some recommendations for clinically relevant goals/objectives in the communication assessment, but the IDT did not include them in her ISP, which was unfortunate.
- In the assessment for Individual #348, the SLP stated: "strengths and interests support possible use of simple signs or pictures to assist communicating needs. Ability to imitate simple signs, expansion not evident in the past. Escape function of his behaviors are possibly related to his communication deficit because he doesn't have a functional way to communicate escape." However, the SLP did not address this clearly identified need through supports and/or direct intervention. The SLP stated that direct therapy was not recommended due to disruptive behaviors and limited attention span, but did not recommend interventions to address his limited attention span, and did not collaborate with Behavioral Health Services staff to identify strategies to provide incentives to gain the individual's cooperation with communication interventions.
- Although the following goals/objectives were measurable, because it was unclear whether or not they were clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #136 (i.e., responding to "stop," responding to music, and turning her head towards staff saying her name).
- In its comments on the draft report, the State disputed the findings for Individual #256. The State's comments show a lack of understanding of clinically relevant and measurable goals. The goal read: "When asked, "[Individual] what do you want?"

[Individual] will independently use picture symbols to request a present object or activity in 6 of 8 trials per session for 3 consecutive sessions by 6/6/18." The problem that this goal was designed to address was the need for Individual #256 to improve his ability to identify pictures as a step towards improving his usage of Voice Output Devices. It is unclear how this goal/objective addressed the stated problem (i.e., it was not clinically relevant). In addition, in terms of measurability, it was unclear how staff would know what Individual #256 wanted, or whether he understood the picture he was choosing or he was just picking a random picture. Finally, although the State asserted that he was making progress on his goal, the QIDP monthly summaries did not support this assertion. As indicated in the audit tool, the Monitoring Team uses the QIDP integrated summaries to determine whether or not the IDT had the information it needed to assess and respond to the individual's progress or lack thereof.

c. through e. As noted above, Individual #207 and Individual #142 had functional communication skills. They were both part of the core group, so full reviews were conducted for them. For the remaining seven 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: Although more work was needed, it was good to see some improvement in the inclusion of data related to communication goals in integrated reviews. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 207	114	136	112	154	256	353	142	348
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	57% 4/7	N/A	N/A	3/3	0/3	N/A	1/1	N/A	N/A	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented:

- Individual #136's monthly reviews included data for each of her three goals/objectives. Similarly, the QIDP included data in the integrated reviews for Individual #256's direct therapy goal.
- According to Individual #112's integrated reviews, no data were available for September, October, or November. The Center submitted the SLP's IPNs to the Monitoring Team, but the QIDP had not included the information in the integrated reviews.

b. Individual #353's IDT discontinued all of his SAPs and supports due to a change of status. However, the IDT provided no indication of his status at that time. The IDT also did not discuss new interventions from which he might benefit or what criteria would be used to determine when he might be ready to resume direct communication therapy.

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: Based on the Monitoring Team's observations to determine if individuals were using their AAC devices functionally, the Center regressed with regard to ensuring the devices were readily accessible to the individuals. As a result, Indicator a will move back to active oversight. The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	335	121	58	55	258	180	307		
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, after Round 11, it moved to the category requiring less oversight. However, based on the Monitoring Team's observations for Indicator b, a number of individuals' AAC devices were not readily available to them. Therefore, this indicator will return to active monitoring.									
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/7	0/1	0/1	0/1	0/1	0/1	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.	Not rated.									
Comments: a. For a number of individuals, their AAC devices were not readily accessible to them. For example, Individual #58's device was behind her head, Individual #55's switch to ask for a break was on a shelf, and Individual #180's device was across the dining room on a shelf. b. It was concerning that often when opportunities for using the devices presented themselves, staff did not prompt individuals to use their AAC devices, or did not respond when the individual did use the device.												

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, one will be moved to the category requiring less oversight. Moreover, 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.

Since the last review, a new admission and placement coordinator was appointed. She was new to this role, but not new to the Center. In addition, the new Post Move Monitor was relatively new, only in his position since around the time of the last review. Since the last review, there were two transitions to the community, one of which failed and the individual returned to the Center after seven weeks at a group home. There were, however, 12 individuals on the active referral list, which means that the APC and her staff will have a lot of opportunity to develop comprehensive and individualized transitions.

It was good to see transition staff taking an active role to educate IDTs and advocate for assertive supports that would promote successful transitions. For example, one individual, the Transition Specialist advocated for Center DSPs to work directly with provider staff.

IDTs made progress in identifying several types of evidence needed to validly confirm their presence, rather than relying on staff interview alone. Often, the three prongs of evidence were specified; visual observation, staff interview, and documentation.

The post move monitor had done some good work in identifying needs that required follow-up by the IDT, and taking appropriate action. One example was identifying the need for additional training for one individual's provider staff at the time of his 90-day post move monitoring visit and arranging for several IDT members to participate in that.

The Center should focus on continuing to improve how it develops CLDP supports that are measurable.

The pre-move training supports remained of considerable concern. To meet criteria, pre-move training supports should address the content of provider staff training as well as describe the staff to be trained, the training methodologies to be used, the competency criteria, and how competency will be measured. It should ensure its written exams are constructed to cover all essential knowledge. Most competency quizzes probed a very small number of the many specific needs and supports for each individual.

Under indicator 2, seven aspects of the set of post-move supports ranging, for example, from behavioral and health/risk needs to employment and/or meaningful day needs were evaluated by the Monitoring Team. The Center still needed to improve how it addressed each of these seven areas in a comprehensive and thoughtful manner.

Post move monitoring was occurring as frequently as required and in all required locations. Overall, the post move monitor reviewed each support, however, a more thorough job was needed in ensuring all required evidence is examined and in providing comments that reflected the depth of his review for each support. This improvement was already evident in the write-up of the post move monitoring visit observed by the Monitoring Team.

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: San Antonio SSLC's CLDPs showed some improvement in the number, breadth, and measurability of the supports included in the CLDP. Many supports were written in measurable terms, but many were not. The primary area for focus is to create strong supports regarding pre-move inservice training and expectations for community provider staff knowledge and skill. For post move supports, many were included, which was good to see, however, as detailed in the comments below, there were many areas in which supports were missing, were not sufficiently comprehensive, or did not include what was noted as needed in various assessments. In these CLDPs, there were instances in which a support was described one way in the CLDP document and another in the post move monitoring checklist, with impact on overall measurability. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	80	207							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments: Two individuals (Individual #80, Individual #207) transitioned from the Center to the community since the last review. Individual #80 transitioned to a group home that was part of the State's Home and Community-based Services (HCS) program, while Individual #207 transitioned to a private six bed Intermediate Care Facility (ICF). The Monitoring Team reviewed these two transitions and discussed them in detail with the San Antonio SSLC Admissions and Placement staff while onsite.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and

community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. Overall, the Center made progress, but did not yet meet criterion for this indicator. To move toward compliance, the IDTs should continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) could accurately judge implementation of each support. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed 13 pre-move supports for Individual #80 and 19 pre-move supports for Individual #207. Some supports focused on health care actions to be taken prior to the transition, ensuring the presence of needed assistive equipment and environmental modifications and/or the delivery of needed supplies. These pre-move supports were typically measurable. Other pre-move supports called for pre-move training for provider staff across several areas of need. To achieve compliance, the Center must describe how it will verify that provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. To meet criterion, pre-move training supports should address the content of provider staff training as well as describe the staff to be trained, the training methodologies to be used, the competency criteria, and how competency will be measured. Overall, the pre-move training supports did not meet criterion for measurability for either individual, as described below:
    - The CLDP for Individual #80 included eight pre-move supports for provider inservice training. Some of these supports indicated which provider staff needed to be trained, which was positive to see, but others did not. For example, the pre-move support for communication indicated both day and home staff would be inserviced, while supports for training on habilitation needs, dining plan, and adaptive equipment indicated only that "staff" would be trained. One of the eight pre-move training supports, for the Psychiatric Support Plan (PSP), indicated the training methodology. The PSP training support also indicated a methodology for competency testing, but did not specify any competency criteria. None of the other seven pre-move training supports specified competency criteria.
    - Individual #80's PMM Checklist did not consistently include important details included in the CLDP supports. For example, the PMM Checklist included six pre-move training supports rather than the eight defined in his CLDP. The CLDP included supports for inservice training for provider staff covering his residential/social needs and another for his habilitation needs. Neither of these was specifically included in the PMM Checklist. Instead, the Checklist included a support that called for Competency-Based Training for Provider staff, but included no detail about the content or competency criteria. The CLDP also included two pre-move supports for inservice of the provider nurse, one to cover nursing needs and supports and another for medication administration recording (MAR.) The PMM Checklist did not include the latter support. It may have been reasonable to combine the two supports, but there was no evidence the MAR training had been so integrated.
    - For Individual #207, the CLDP included eight pre-move training supports. Some of these supports, including those for behavioral, dental care, and nutritional supports, did provide some detail about the required content of the training. None, however, made it clear if the prescribed content also represented the specific competency criteria needed to confirm essential staff knowledge or how that knowledge would be measured.
        - For example, the CLDP included four inservices to be provided to the provider RN. Three of these were straightforward, calling for the Center registered nurse case manager (RNCM) to inform the provider nurse about the scheduling of appointments with the community primary care physician (PCP) and psychiatrist. The

evidence required was confirmation from the Center RNCM through a service note. In order to more accurately measure the knowledge of the provider nurse, which would be the desired outcome, the Center could have at least obtained a signed confirmation from that staff; a more reliable approach would be to administer some sort of competency testing that confirmed the provider nurse's awareness of Individual #207' specific individualized needs. The fourth required inservice support was much more extensive in terms of topics to be covered, such as medications, nursing needs, medical needs, and information on the physical nutritional management plan (PNMP), but again offered no specific requirements for competency or confirmation the provider nurse was knowledgeable of this individual's specific needs.

- The pre-move training support for Individual #207 did include some specific details about target behaviors, settings, and antecedents and precursors, but did not describe the training methodology or how competency would be demonstrated. The required evidence indicated only that training materials and a signature sheet would be obtained. Attendance at the training would not be sufficient to demonstrate learning had occurred to the needed level of competence. The Monitoring Team also reviewed documentation related to the training, which included a four-question quiz asking the learner to name one target behavior, to list one psychiatric diagnosis; to answer true/false as to whether his current plan contained the use of restraint and what was the level of ID. Given the extent of his behavioral needs, this quiz, which was administered verbally, did not suffice to measure needed staff knowledge.

- Post-Move: The respective IDTs developed 42 post-move supports for Individual #80 and 39 post-move supports for Individual #207.
  - For Individual #80, many of his post-move supports were measurable and specified several types of evidence needed to confirm their presence. This was positive, but not yet consistent. In this CLDP, the review identified instances in which a support was described one way in the CLDP document and another in the PMM Checklist, with impact on overall measurability. For example:
    - The CLDP included specific criteria for a support for the provider to provide quarterly opportunities to visit his parents, with the assistance of direct support staff to transport him and maintain line of sight supervision during the visit. Evidence required included family interview, staff interview, and documentation review. This was a fairly well constructed support that made clear what needed to be done, as well as when and how it needed to be done. It also required several forms of evidence. On the other hand, this measurability was not faithfully reflected in the PMM Checklist, which required only that he would visit his family quarterly beginning within 30 days of transition. It did not specify the provider's responsibility for transportation or for providing line of sight supervision.
    - Similarly, the CLDP included two supports related to obtaining two blood tests: a Complete Blood Count (CBC) and a Comprehensive Metabolic Panel (CMP). The first called for annual monitoring and the second indicated that he required those labs to be completed every six months for medication monitoring. The PMM Checklist included one support for the annual labs.
    - Also, there were CLDP supports that were not included in the PMM Checklist at all. Individual #80's CLDP included two supports about his psychiatric support plan (PSP); the first was to continue the PSP and to track and monitor related symptoms, and the second was for the community board certified behavior analyst

(BCBA) to review the plan by within 60 days and modified as needed. Neither of these were included in the PMM Checklist.

- For Individual #207, many post-move supports were measurable and specified several types of evidence needed to confirm their presence. This was positive, but not yet consistent. A good example of a measurable support was to continue his dining precautions to prevent choking, which listed the dining instructions and his precautions. This support required three prongs of evidence, including visual observation, staff interview, and documentation in the observation note and/or daily log. Other examples of measurable post-move supports defined when labs were due; how often he should shave, with verbal prompting from staff; and, to see community health care providers within a specific timeframe after transition. Each of these also included a good description of the evidence needed to document the support was in place as needed. Examples that did not meet criterion for measurability included:
  - The CLDP included a post-move support for a bowel movement log to be kept to monitor for constipation. To meet criterion for measurability, the support should have described the expected baseline and what variance from that would require reporting to the nurse. When developing supports, the IDT needed to consider the ultimate purpose, which in this case was to ensure any issues with bowel movements were promptly recognized and addressed, and ensure the content addresses it.
  - Another post-move support indicated he would participate in off-campus outings scheduled on the peer calendar from the resident council meetings. This did not define any expectation about how often he would have opportunity to participate in community activities.

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

- Past history, and recent and current behavioral and psychiatric problems: Neither of these CLDPs met criterion. The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems To achieve criteria, the IDTs should continue to make improvement toward developing comprehensive supports to address behavioral and psychiatric needs and to ensure provider staff have a sufficient understanding of behavioral history. Findings included:
  - Per Individual #80's behavioral health assessment (BHA), his PBSP had been discontinued in favor of a PSP due to a low level of target behaviors. These behaviors included physical and verbal aggression (punching, hitting, and pushing others); self-injurious behavior (slapping, punching and hitting himself), and psychotic behavior (talking to people that are not present, attempting to leave his home and wander at night, removing his clothes and attempting to remove peers from their beds). The BHA further indicated the absence of activities and social attention might increase the likelihood that he may exhibit these behaviors. It further detailed a number of environmental supports that lessened the likelihood of these behaviors, such having choices, keeping a routine, and being in a calm and quiet environment. It recommended keeping him occupied with preferred activities because he may be more likely to display psychiatric symptoms when not engaged. Finally, the BHA provided a discussion of what steps to take in the event of aggressive, self-injurious or psychotic behaviors.

- The pre-move training support did not specifically address the need for staff knowledge of any of these behavioral needs or strategies.
- The CLDP did not include supports for any of the environmental strategies.

- The CLDP included post-move supports for ongoing psychiatric consultation on a quarterly basis, which was positive. It also included supports to continue a formal PSP to track and monitor symptoms and for that plan to be reviewed by the community providers BCBA within 60 days and modified as necessary. As described above, neither of these latter two supports had been included in the PMM Checklist and were not being tracked for implementation.
- The post-move supports did not require any evidence be obtained to demonstrate staff knowledge of his behavioral needs and interventions.

- Individual #207's history included a significant history of aggression, property destruction, threatening to hurt authority figures and throwing furniture, suicidal threats when depressed or angry, refusals, and self-injury. Per the BHA, his only maladaptive behavior at the time of transition was starting arguments with black peers and making racial slurs. The CLDP included a pre-move training support that described these target behaviors, as well as settings and antecedents and precursors, but it did not address any of the behavioral strategies for prevention or intervention. The CLDP also included a reference to a history of inappropriate sexual behaviors, as did several assessments; none of these provided any description of the behavior in question. As described under Indicator #1 above, the Center did not establish supports to ensure staff were knowledgeable of these needs and appropriate strategies to address them prior to his move. This was true even in light of concerns expressed by both the psychiatrist and psychologist prior to the transition, and a spate of behavioral incidents, including one crisis restraint, in the weeks leading up to that move.
- The post-move supports called for continuing Individual #207's PBSP, but did not provide any details as to how staff should prevent or address the behaviors.
- The IDT did not develop a clear and assertive set of supports regarding the needs related to management of Individual #207's six psychotropic medications, but should have done so, especially since the CLDP noted that pharmacological management may have played a part in Individual #207's decompensation in his previous failed transition. The psychiatry assessment indicated some concern or at least uncertainty related to this proposed transition, stating," … all of a sudden, whoever decides when to discharge a patient into the community decided to discharge (Individual #207). I assume he's stable now and he's back to previous baseline." His recommendation was for the community treating psychiatrist to read his discharge summary and continue current pharmacological management. The BHA indicated disagreement with the psychiatry recommendation to continue the current regimen, indicating he believed Individual #207 was receiving too many medications at sub-optimal doses. The IDT did not document discussion that resolved these issues, but developed supports to continue the current pharmacological management and for the community psychiatrist to review the number of medications and adjust as needed. Further, the IDT developed a support to defer management of his Haldol to the community PCP. The IDT did develop another support for the community psychiatrist to document receiving the psychiatric assessment, but given the complexities as described above, the IDT should have developed a more assertive support for transfer of knowledge.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed some good supports related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments, but this was not consistent. To meet criteria, the IDTs still needed to develop comprehensive and cohesive supports. For example:
    - Neither CLDP included a clearly stated and comprehensive support that described the needed level of supervision.
    - For Individual #80, documentation indicated the IDT had been concerned that he may be developing dementia. For example, the PSP indicated a dementia work-up had been completed because the IDT had suspected it for several years, but results were inconclusive. Further, the behavioral health assessment (BHA) stated a psychotropic medication had been discontinued because it was contraindicated for an individual with dementia. The CLDP did not include any supports for knowledge of this history or what symptoms the IDT had observed that may need to be monitored for further follow-up.
    - Individual #80 had a diagnosis of atlanto-axial ligament laxity, and the medical assessment indicated he should have a screening every two years. The CLDP did not include a related support.
    - Per the RN assessment, Individual #80 had a significant history of skin infections, including Methicillin-resistant Staphylococcus aureus (MRSA) and cellulitis, and skin integrity was tracked daily at the Center. The CLDP did not include any supports for direct support staff to be aware of the need to monitor for or report any skin issues.
    - Individual #207 had a diagnosis that carried a high risk of obesity and a history of having weighed over 400 pounds. He had lost approximately 220 pounds in a previous community setting. For the most part, he had been able to sustain the weight loss until this past year, in which he had gained approximately 11 pounds. The IDT did not define a clear and careful set of post-move supports for this need. This may have been because he was transitioning to a home that specialized in serving individuals with this diagnosis (Prader-Willi Syndrome). Two supports indicated he should follow a menu designed for his diagnosis or a low-calorie diet, with limited low-calorie snack per his preference. They also indicated the provider should monitor his weight and it should reflect no significant weight changes per a standard set of guidelines, including, for example, no more than five percent change in one month. The CLDP did not specifically require the provider to weigh monthly; this was a concern because the CLDP narrative indicated the provider weighed quarterly. The IDT also did not develop an assertive and measurable post-move support for exercise, although this was recommended in several assessments. Instead, the support called for allowing opportunities for various forms of exercise in the community or exercise room on a weekly basis. His ISP had called for him to engage in a formal exercise program three times a week. Per interview with transition staff, the IDT had information that the new home had a gym onsite and a large open field and that provider staff reported the individuals spent a good deal of time outside. While it was appropriate to consider such environmental factors that may be conducive to his needs, the IDT still needed to define an expectation rather than assuming the presence of the gym and field would be sufficient to ensure adequate exercise.
    - The CLDP did not include supports for staff knowledge of Individual #207's relatively recent choking history resulting from consuming food outside his prescribed diet texture. Two choking incidents had occurred in 2016 because he ate cookies and chips.

- What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Both CLDPs addressed some of these outcomes, but neither did so

in an assertive manner. Findings included:

- For Individual #80, the important outcomes cited in the CLDP included participating in an activity of choice at the YMCA at least 12 times a year, making friend at the YMCA, and buying a diet Coke after going to work daily. The CLDP supports included a support for the provider to assist him to make application for a public swim facility within 90 days. This did not define an outcome of actual participation on an ongoing basis, such as 12 times per year. The CLDP did not include supports for making a friend or for buying a diet coke at the end of the day. As described above, it was positive the CLDP addressed visiting with his family as a support.
- For Individual #207, important outcomes were listed as living closer to his family, having regular contact with his family, getting a job, and having the opportunity to go to a Texas Ranger or Dallas cowboy game with his family. The CLDP did include supports for visiting family and for the opportunity to attend these specific sporting events with them. The support for regular contact indicated that he would have assistance from the provider to have visits with his family at least monthly; per interview with transition staff, this would have resulted in significantly more family contact than had been the norm. The support did not make clear, however, what assistance the provider would make available to facilitate the family visits, or how assertive a role they should play. In the time Individual #207 was in the home, the only visits with his family had been when they came to see him. The employment outcome was not addressed, as described under the next bullet.

- Need/desire for employment, and/or other meaningful day activities: Neither CLDP assertively addressed individuals' needs and preferences in this area and did not meet criterion:
  - For Individual #80, the CLDP included supports to attend a day habilitation program for five days per week. The CLDP supports did not address opportunities to perform work and earn money, which he was able to do at the Center. His ISP noted he had been able to increase his earnings and had established a goal to increase them further. The CLDP also did not assertively address meaningful day activities in the community on an ongoing basis, with the sole support to attend four community outings per month.
  - For Individual #207, his ISP and assessments indicated he should focus on community employment and that he might do well working in a video store or as a ticket-taker. Per the CLDP narrative, one of his important outcomes was to get a job. The CLDP included only a post-move support for the provider to complete an assessment of his job interests and potential work opportunities within 90 days. The support did not define an expectation for an actual employment outcome for Individual #207.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined supports regarding behavioral strategies that included some elements of positive reinforcement and other motivating components, but this was not yet consistent. For example:
  - As described above, the IDT did not develop needed environmental supports for Individual #80 to lessen the likelihood he would exhibit behaviors.
  - For Individual #207, the IDT identified he was ambivalent about moving, in part because he would miss his friends at the Center. The documentation indicated he told staff of this ambivalence, stating he half-wanted to go and half-wanted to stay. In two different pre-move ISPA meetings, the IDT indicated he would need to be able to call and speak to his friends regularly and that his QIDP would the provide address of the facility and phone number so he could keep

in contact with staff and peers. The IDT did not develop related supports.
    - Similarly, prior to Individual #207's transition, the IDT and his LAR had identified behavioral concerns related to stress of the upcoming move. The IDT provided daily counseling and yoga prior to the move to address this at the Center and the LAR indicated she would like for these types of supports to be continued after the move. The IDT did not develop any related supports.

- Teaching, maintenance, participation, and acquisition of specific skills: Based on their needs, the CLDP for these two individuals did not assertively address needs in this area and did not meet criterion. Findings included:
    - For Individual #80, the CLDP included a single support to participate in skills acquisition upon completion of assessment at day habilitation within 30 days of moving. Per his ISP and assessments, he had many needs for skill acquisition that would have supported his community safety, independence, and participation. These included money management, laundry, and pedestrian skills. The IDT needed to discuss his specific needs in the area of skills acquisition and develop assertive supports.
    - Overall, the IDT did not address Individual #207's learning needs in an assertive fashion. The CLDP included staff prompting to continue to participate in doing his own laundry and shaving independently, which was positive. It did not specifically address new skill acquisition, however, even though his LAR indicated she wanted him to focus on independent living skills, so that he might someday be able to live on his own. The IDT discussed during the CLDP that the provider would assess his money skills and work with him in the area of balancing his checkbook, but did not include a related support. Instead, the IDT deferred to the provider to complete an assessment of his independent living skills within 30 days, which would then be used to develop goals at the day program. The support did not define any specific expectation of when this would occur.

- All recommendations from assessments are included, or if not, there is a rationale provided: Overall, San Antonio SSLC had a good process in place for documenting discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional, recommendations. To continue to move toward compliance, the Center should focus on ensuring the following:
    - The CLDP should provide a clear justification when it declines to include recommendations from any discipline assessment. For these two CLDPs, that process was not yet consistent. For example:
        - Several of Individual #80's assessments recommended he participate in structured exercise on a regular basis. In each case, the CLDP documented the IDT decided not include this in the final recommendations, but never provided a justification for that decision.
        - For Individual #207, the nursing assessment recommended an annual vision examination and for monthly vital signs to be monitored monthly and as needed. The CLDP did not include related supports or provide a justification why they were not needed.
    - The IDT should take care to ensure all accepted recommendations are reflected in the final supports. For these two CLDPs, that process was not yet consistent.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: Post move monitoring was occurring as required. This has been the case for this and the previous two reviews, too. Therefore, indicator 3 will be moved to the category of requiring less oversight. Overall, post move monitoring needed to be conducted somewhat more thoroughly, so that the content of the support is fully evaluated and that the three prongs of evidence are explored. More detailed commentary in the post move monitoring report was needed (already evident in the write-up of the post move monitoring visit observed by the Monitoring Team). The APC and the PMM were extremely receptive to feedback from the Monitoring Team. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	80	207							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's assessment is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	0% 0/1	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	N/A	N/A							
Comments: 3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes, were done in the proper format, and occurred at all locations where the individual lived or worked. 4. The PMM Checklists did not consistently provide valid and reliable data. The PMM included comments regarding the provision of												

every support, but these sometimes did not include sufficient detail to reliably ascertain whether the supports were implemented as required. To continue to move toward compliance, the Center should work toward improving overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports. In some supports, the language was broad and vague, while other supports were not included in the PMM Checklist at all, as described in Indicator #1.

As also describe above in Indicator #1, it was positive the Center had frequently described more than one prong of evidence (observation, documentation interview) the PMM needed to review for the purposes of validity and reliability. To continue to move toward compliance, the PMM should consistently provide comments showing that all required evidence has been reviewed (or document a valid reason why this was not needed or did not occur).

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP, but this was not yet consistent. Examples of supports the provider had not implemented included:

- For Individual #80, examples of supports that had not been provided included:
    - At the time of the 90-day PMM visit, he had not received an assessment for skills acquisition and no such plans were in place.
    - Also at the time of the 90-day PMM visit, the provider had not assisted him to make an application for a public swim facility or other such opportunity.
    - At the time of the seven and 90-day PMM visits, the evidence did not indicate staff had completed hourly bed checks at night as required, and did not have knowledge about his use of ear plugs for showering, bathing, and/or swimming.
    - He had not been to visit his family, but the provider and IDT had not been able to contact them.
- For Individual #207, the provider had not identified job interests, potential employment opportunities or independent living goals.

As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack clarity and measurability in the supports as written and/or the lack of valid and reliable data. In other instances, the IDT did not include all needed supports as identified throughout the CLDP. Examples of supports not in place as required included:

- For Individual #80, a support called for the PMM to observe the correct food texture, but the PMM Checklist indicated only that staff had verbally confirmed the correct texture. Similarly, a support called for a 1200 calorie diet, but the PMM did not document any evidence about the presence of this support at the seven and 90-day PMM visits.
- As described in Indicator #1, two supports related to Individual #80's PSP had been excluded from the PMM Checklist and, thus, had no data to confirm presence.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but this was not yet consistent. Again, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack of valid and reliable data.

- For Individual #80, as described above in Indicator #6, the PMM marked supports for diet texture and the 1200 calorie diet as in place, but did not provide sufficient evidence to support that finding.
- At the time of the 90-day PMM visit for Individual #80, the PMM marked the support for bathing as in place, even though the comments indicated provider staff was not able to accurately describe bathing process and did not know about ear plugs. It

was positive the PMM showed the staff where the ear plugs were kept and described the importance of using them for showering, bathing and/or swimming, but the fact that the PMM took good follow-up action did not, therefore, indicate the support was in place.

- For Individual #207, the PMM marked as in place the support for completing an assessment of independent living skills to be used to develop goals for the day program, but the evidence did not support that finding. The provider stated an assessment had been completed, but they had been unable to develop goals due to his behavior. Since it had not been fully completed, the PMM should have marked the support as not in place and to trigger needed follow-up.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. To continue to move toward compliance, the Center should consistently identify the need for and implement corrective action. Findings included:

- For Individual #80, it was positive the PMM followed-up with the provider about the need for new staff training after discovering that all incumbent staff had left between the 45- and 90-day PMM visits.
- The PMM Checklists for Individual #80 did not provide evidence follow-up had been implemented about the failure of the provider to make application for a public swim facility or the completion of an assessment for skills acquisition.
- The PMM Checklists did not indicate additional follow-up the IDT needed to take regarding contact with Individual #80's family. For Individual #207, PMM documentation indicated as early as 6/29/17 that the PMM and Lufkin APC/staff (Lufkin SSLC was providing some support because of the distance from San Antonio SSLC) had spoken with the provider regarding behavioral concerns at the 45-day PMM visit, which should have triggered immediate follow-up, based on the severity of behavioral needs. The provider indicated at that time that staff and peers were not safe. The provider QIDP indicated she had requested technical assistance from Center staff, and reported they had not, however, received this. Additional documentation provided by the Center indicated the IDT members had made some effort to respond between 7/6/17 and 7/27/17. Some gaps were still evident in the communications between the Center and the provider. This was further complicated by the distance between the Center and the provider, which made it difficult to provide onsite assistance on a more spontaneous basis.

9-10. The Monitoring Team observed the conduct of post move monitoring for the 12-month visit for Individual #188. His day and residential provider was R & K Services in San Antonio. The day program and home were visited, though the individual had left the day program by the time of this visit, so the PMM will have to return for another observation for that aspect of the review. The home was also visited. The individual was, overall, doing well, had a consistent routine, and showed little problematic behaviors or issues. A long-term direct care staff was interviewed and was knowledgeable about the individual. The PMM's interaction style with the individual and staff was pleasant and set the occasion for them to be comfortable with the post move monitoring activities. The PMM went through the PMM checklist, item by item. Most items were thoroughly examined, but for some, the requirements in the support were not examined as per the specific wording in the support. For example, the support for formal training for shaving was not being implemented. Some attention to this and to including more detail in the PMM report are required. The report was an accurate reflection of what was observed by the Monitoring Team.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: One individual did not experience any negative events. The other had a very difficult transition and ended up returning to live at the Center. A number of actions were identified that should have been taken prior to his move (e.g., as part of his transition process, more comprehensive supports in his CLDP, attention to events in the weeks immediately prior to the transition). This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	80	207								
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.	50% 1/2	1/1	1/1								

Comments:

11. Individual #80 had not experienced a PDCT event. Individual #207 had returned to the Center due to behavioral concerns, including physical and verbal aggression, attempts at self-injury, threats of suicide and several instances of leaving the community home. The documentation indicated a medication change was initiated in late June 2017, but his behaviors increased and the dosage was returned to baseline. The IDT met on 8/2/17 and agreed he should return to the Center.

The IDT documented what had occurred since the transition, but did not assess whether the circumstances were preventable or whether anything may have been done differently in the transition process to change the outcome. Making such assessments are an important part of the PDCT process, particularly for process improvement to support future transitions. For example, the IDT should have considered the following, at a minimum:

- The CLDP should have included comprehensive pre-move training supports that clearly laid out needed staff competencies to meet his behavioral needs, including history and preventative and interventional strategies, and ensured provider staff demonstrated those competencies.
- The IDT should have developed assertive supports to address the potential concerns about pharmacological management.
- The IDT should have followed through and developed supports that would have allowed Individual #207 to maintain important relationships with peers and staff at the Center.
- The IDT should have developed continuing supports to assist Individual #207 to manage the stressors he was experiencing with transition.
- The Center should have evaluated how the PMM process failed to identify the ongoing behavioral concerns. In this transition, another Center had responsibility for the PMM visits for Individual #207 due to the distance from San Antonio SSLC. Per interview, the San Antonio SSLC PMM acknowledged not having much contact with the PMM staff from the other Center. Given the geographical distances involved in some transitions in Texas, it may be practical for Centers to share PMM resources. When

considering this option, the respective Centers should develop protocols and, when needed, specific supports to ensure the needed level of communication. SSLC state office staff also participated in this interview indicated this topic would be taken under advisement at that level.

- The IDT should have considered whether it responded with needed urgency once the severity and nature of the behavioral issues were identified.

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: Some aspects of some of these indicators showed progress and met criteria. For instance, with sustained high performance, indicators 13 and 18 might be moved to the category of requiring less oversight after the next review. Areas of focus are the content of the transition assessments, especially regarding the upcoming new home and day settings for the individual, and ensuring thorough training of provider staff. The indicators for the various transition activities were met for one, but not both individuals (indicators 16, 17, and 18). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	80	207							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	50% 1/2	100% 1/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as	50%	0/1	1/1							

	dictated by the individual's needs.	1/2									
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	50% 1/2	1/1	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% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments:

12. Assessments did not yet consistently meet criterion for this indicator. This remained an area of need. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Overall, disciplines provided assessments for the CLDP and consistently met criterion for timeliness, which was positive. To continue to move toward compliance the Center should ensure it obtains an updated IRRF and updated pharmacy/QDRR assessments. For these two CLDPs, the Center did not provide these assessments.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: IDTs still needed to ensure that assessments were comprehensive in scope and reflected current status. For example, the psychiatric assessments were very brief and provided little information. Others did not consistently provide current status. This included the nursing assessment for Individual #207, which did not update his status as an active smoker.
- 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 yet thoroughly provide recommendations to support transition. Per interview, the transition staff reported they had been working with some disciplines on an individual basis to review and refine recommendations, which was positive. This also applied to the recommendations addressed in the next bullet.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Assessment recommendations varied considerably in comprehensiveness and individualization. The IDT for Individual #207 acknowledged the recommendations from the functional skills assessment (FSA) were not appropriate for the community. His nursing assessment also provided few specific recommendations appropriated for the community.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; and 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. Both CLDPs met criterion for this indicator. Section IV of the CLDP document, entitled Community Living, provided a summary of transition activities that described the involvement of the individual and LAR/ family, the LIDDA and Center staff. These were helpful in understanding how the Centers transition processes ensured necessary participation.

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: Training provided to community provider staff did not yet meet criterion for these two CLDPs. The Monitoring Team requested and reviewed the materials, rosters, and competency testing for all training provided related to these transitions. Findings included:

- The IDTs inconsistently identified the expected provider staff knowledge or competencies that would need to be demonstrated. Neither the supports nor the training materials clearly defined criteria that would demonstrate provider staff were competent to provide for the individuals' health and safety.
- The IDTs did not consistently identify the training methodologies appropriate to each training need.
- To continue to move toward compliance, the Center should ensure its written exams are constructed to cover all essential knowledge. The testing materials reviewed by the Monitoring Team fell short of this mark. Competency testing did not clearly document that provider staff had knowledge of all essential supports based on each individual's needs. Most competency quizzes probed a very small number of the many specific needs and supports for each individual.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any completed, summarize findings and outcomes. Findings included:

- It was positive that both CLDPs included specific requirements for nurse-to-nurse collaboration.
- The IDT also needed to determine if any additional collaboration was needed and document that discussion. Per the psychiatry assessments for both individuals, the psychiatrist recommended the IDT obtain a signature from the community clinician acknowledging he/she had read the assessment. This should have sparked a conversation among the IDT about whether this indicated a need for a more formal collaboration. This was especially true for Individual #207. The psychiatry assessment and the behavioral assessment described concerns that would have benefited from direct collaboration.

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, based on individual needs. Findings included:

- Individual #80's CLDP did not provide this statement. A pre-move ISPA indicated the IDT recommended a PNMP Coordinator should visit the home to ensure the needed bathing equipment was in place. The documentation did not provided evidence this had occurred. Per the available documentation, the QIDP and Transition Specialist toured the home and sent pictures of the bathroom to the occupational therapist (OT). The IDT should have confirmed this met its intent. The documentation did not make clear the needed modifications had been made at that time, in any event.
- For Individual #207, the CLDP met criterion. The pre-move ISPA documented the IDT agreed that the BCBA and QIDP would visit to survey the home and facility, and this was referenced in the CLDP narrative

17. 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. 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. CLDP documentation described some positive practices implemented for both transitions.

- The IDT for Individual #80 developed specific post-move supports for San Antonio SSLC staff to work shifts at the home and

day program, on his first day of transition at the behest of the Transition Specialist. This was a very positive practice and it was good to see transition staff sharing their expertise and providing this sort of technical assistance to the IDT.
- The CLDP for Individual #207 did not provide the required statement or other evidence of compliance.

18. LIDDA participation: Per the documentation, these two CLDPs met criterion.

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. This was positive, but timeliness is only one component of compliance for this indicator. It is also essential the Center can directly affirm provider staff competency to ensure health and safety prior to relinquishing day-to-day responsibility. The PMSRs for these two individuals did not accomplish this. Findings included:
- While the PMSR documents did not provide any evidentiary documentation to confirm pre-move supports were in place, the PMM Checklist did include some evidence and/or a comment to demonstrate the presence of the respective support. For example, the PMM documented visual verification of the required grab bars and food processor for Individual #80. This was positive.
- The CLDP included numerous pre-move supports for pre-move training, but these did not meet criterion for ensuring that provider staff were competent for either individual, as described above. The pre-move documentation in the PMSR and/or PMM Checklist did not provide any additional confirmation of staff knowledge or competence.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: One individual moved in a short period of time. The other had a number of delays, some of which were out of the control of the Center, but others of which were under the control of the Center. The Center had put in place protocols to avoid re-occurrence. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	80	207							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	50% 1/2	0/1	1/1							

Comments:

20. One of two CLDPs met criterion for this indicator.
- Individual #80 was referred on 7/26/16 and transitioned on 10/10/17, which exceeded 180 days. The Transition Log documented some delay due to the provider having to locate a different home to accommodate his need for grab bars to be installed. The log also documented some additional delay between the 180-day IDT meeting in June 2017 and the eventual transition date. Some of the delay was attributed to transition staff advocating for additional pre-placement experience, which was an appropriate justification. Some additional delay, however, was due to the absence of needed eligibility documents, which was not discovered until well into the transition process. Transition staff acknowledged this delay could have been avoided if the document issue had been identified sooner. It was positive the Center had revised its practices to ensure a timely review of needed records and documents was included as an action plan in new 14-day ISPA meetings.
- Individual #207 was referred on 4/5/17 at his LAR's request and transitioned on 6/6/17. This was within 180 days.

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 within past two years, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected 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
PNA	Psychiatric nurse assistant
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan

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