

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.

Of note was the stability of much of the Center's management team and department director staff. Similarly, the Center had an experienced set of unit directors. They were knowledgeable about their units, facility operations, and staffing needs. Unit meetings contained a lot of relevant information about the past day and about the upcoming day. The Center also had a number of experienced house managers. All of this sets the stage for good progress to occur.

The Monitoring Teams have some comments regarding two individuals for inclusion in this executive summary:

- For Individual #134, there was a need for her to have a strong plan for transitioning back to the community. Moreover, this planning will be more successful if the Center can obtain more information about her services, supports, and problems since her discharge a number of years ago.
- For Individual #357, genetic testing regarding Rett Syndrome seemed warranted as well as developing a better definition and categorization system for her numerous falls.

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, 17 of these indicators were in the category of requiring less oversight. During this review six other indicators had sustained high performance scores and will be moved to the category of requiring less oversight. These were in restraint management and incident management.

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

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

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

Restraint

There was a decreasing trend in the usage of crisis intervention restraint across the nine months of the review period, though the total number of crisis intervention restraints during this period was higher than during the last period. The Center made the case that the higher numbers were due to two individuals and showed that the trend lines for both of those individuals were also decreasing.

San Antonio SSLC maintained good performance in the administration and management of crisis intervention restraint. There was no longer any usage of PMR-SIB. This was a multi-year project to reduce the usage of PMR-SIB to the point where there are now no individuals with that intervention. In cases of crisis intervention chemical restraint, there was good monitoring and follow-up post restraint was done.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; providing more detailed descriptions of

individuals' mental status, including specific comparisons to the individual's baseline; in IPNs and IView, documenting injury assessments; and documenting respirations, even when individuals refuse other physical assessments.

Abuse, Neglect, and Incident Management

Overall, there was improvement since the last review. Staff knowledge of abuse and neglect reporting was good. San Antonio SSLC demonstrating that it was providing immediate protections for individuals. There was much improvement in the identification of recommendations in investigations. Most, but not all, recommendations were implemented.

There were some problems with investigations. Some were a result of HHSC PI actions:

- About one-third of the investigations were not completed within the required 10-day time period and did not have proper extension documentation.
- In one HHSC PI case, the investigator did not interview the staff involved.

Some were a result of Center actions:

- Circumstances around late reporting were not fully explored.
- Supervisory reviews were not detecting the kinds of problems identified by the Monitoring Team.

San Antonio SSLC corrected the problems it had with audits of significant injuries. On the other hand, non-serious injury investigations were not conducted for three individuals when they should have been.

Other

ISPs documented that IDTs were discussing and reviewing PTS for some individuals. For most of individuals, some type of plan was developed and implemented to potentially reduce future need for PTS, though there was little/no review of progress.

Over this review and the last one, the Center completed clinically significant drug utilization evaluations (DUEs), which was good to see.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.	
Summary: There was a decreasing trend in the usage of crisis intervention restraint across the nine months of the review period, though the total number of crisis intervention restraints during this period was higher than during the last period. The Center made the case that the higher numbers were due to two individuals and showed that the trend lines for both of those individuals were also decreasing.	Individuals:

<p>There were no longer any individuals at San Antonio SSLC who had protective mechanical restraint for self-injurious behavior. The usage of restraint, PTS, and/or TIVA for medical and dental procedures was low; these data should be incorporated into the Center's overall restraint review systems.</p> <p>These two indicators remain in active monitoring.</p>											
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	92% 11/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
<p>Comments:</p> <p>1. Twelve sets of monthly data provided by the facility for the past nine months (January 2018 through September 2018) were reviewed. Overall, there was a decreasing trend in the usage of crisis intervention restraint across the nine months of the review period. That being said, the total frequency of crisis intervention restraint over the nine-month period was the highest at San Antonio SSLC since the Monitoring Team began reporting on this in early 2015. Given that one of the goals of managing crisis intervention restraint usage is to work on reducing usage when possible, the decreasing trend was good to see. Therefore, this sub-indicator is scored positively.</p> <p>In addition, the Monitoring Team has often suggested that Centers create secondary/supplemental graphs to provide support for their verbal hypotheses regarding increases and decreases in restraint usage. Sometimes, Center staff say that increases in crisis intervention restraint are due to new admissions. If so, a secondary graph that removes new admissions for their first few months (e.g., three months) might support that.</p> <p>At San Antonio SSLC, the staff said that the overall higher frequency of restraint was due primarily to two individuals (Individual #184 Individual #95). After discussion while onsite, the Center created secondary graphs that showed the frequency of crisis intervention restraints without each, and without both, of these individuals. The Center also created graphs of crisis intervention restraint frequency for each of these two individuals. A review of this set of graphs showed descending trends for the Center as a whole as well as for each of the two individuals and that these two individuals accounted for more than half (53%) of all crisis intervention restraints during the nine-month review period.</p> <p><u>Note:</u> Crisis intervention restraint should be used when there are imminently dangerous circumstances for which the staff need to intervene with crisis intervention restraint to protect the individual and others from immediate and serious risk of harm. Although the Monitoring Team looks for decreasing trends in the usage of crisis intervention restraint, appropriate usage of crisis restraint does not prevent the Center from moving forward towards substantial compliance with the protection from harm restraint aspects of the Settlement Agreement.</p>											

The usage of crisis intervention physical restraint paralleled the overall usage of crisis intervention restraint because most crisis intervention restraints were crisis intervention physical restraints. The average duration of crisis intervention restraints, however, was more than six minutes, the second highest in the state. The usage of crisis intervention chemical restraint remained low, and there was one month in which crisis intervention mechanical restraint was applied for one individual. It has since been discontinued as an option for her (Individual #357) because it was difficult to implement safely and successfully.

The Center reduced the usage of protective mechanical restraint for self-injurious behavior (PMR-SIB) to zero. The Center was working to get to this point for a number of years. There was also a decreasing trend in the number of individuals who had one or more crisis intervention restraints each month. There was one injury reported to have occurred during crisis intervention restraint application, deemed non-serious (but see below regarding documentation of nursing post-restraint reviews).

There were few occurrences (three) of usage of non-chemical restraints for conducting medical or dental procedures, no usage of pretreatment sedation for medical procedures, zero to two usages of pretreatment sedation for dental procedures each month, and about nine individuals had TIVA used for dental procedures each month. The data and information on these four sets of data were from the dental/medical department. The Monitoring Team recommends that these data get incorporated into the Center's overall review of restraints (i.e., crisis intervention restraint, and interventions needed to complete medical and dental procedures).

Thus, facility data showed low/zero usage and/or decreases in 11 of these 12 facility-wide measures (use of crisis intervention restraint; use of physical, chemical and mechanical restraint; restraint-related injuries; use of PMR-SIB; number of individuals with crisis intervention restraint; 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).

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. Of these six individuals, all six received crisis intervention physical restraints (Individual #134, Individual #118, Individual #139, Individual #357, Individual #375, Individual #385), and one received crisis intervention chemical restraint (Individual #375). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for four of the six (Individual #118, Individual #357, Individual #375, Individual #385). The other three individuals reviewed by the behavioral health Monitoring Team had no occurrences of crisis intervention restraint and were scored positively for this indicator.

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: San Antonio SSLC maintained good performance in the administration and management of crisis intervention restraint. Indicators 10 and 11 maintained high performance and will be moved to the category of requiring less oversight. However, please see comments below regarding indicator 11 and the need for more detail in the IRRF. The issue of time entry problems with IRIS regarding crisis intervention consultation and implementation continued and needs to be fixed.

Individuals:

Indicator 9 showed continued improvement and will remain in active monitoring, the only indicator in this outcome that remains in active monitoring.											
#	Indicator	Overall Score	134	118	139	357	375	385			
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.										
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.										
7	There was no injury to the individual as a result of implementation of the restraint.										
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.	50% 1/1	1/1	Not rated	0/1	Not rated	Not rated	Not rated			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	90% 9/10	2/2	2/2	2/2	1/1	1/2	1/1			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 10/10	2/2	2/2	2/2	1/1	2/2	1/1			
<p>Comments:</p> <p>The Monitoring Team chose to review 10 restraint incidents that occurred for six different individuals (Individual #134, Individual #118, Individual #139, Individual #357, Individual #375, Individual #385). Of these, nine were crisis intervention physical restraints, and one was a crisis intervention chemical restraint. 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.</p> <p>9. When criterion for indicator 2 is met, this indicator is not scored. That was the case for four of the six individuals. For the other two individuals, all of the sub-indicators were met for one individual (Individual #134). For the other individual (Individual #139), there were several actions taken over the last few months, including the retraining of staff, medication changes, and the addition of sensory materials. In his August 2018 behavioral health progress note, content indicated that PBSP data were not representative of his actual behavior. Further, aspects of his ISP were not consistently implemented.</p> <p>10. One crisis intervention restraint, for Individual #375 6/12/18, for crisis intervention chemical restraint, was scored 0 because of conflicting data/time information regarding notification of behavioral health services versus the time the restraint was performed. This is a recurring problem at many Centers, and seems to be to IRIS entry limitations. This was the same issue as during the last review.</p>											

11. There should be, but wasn't, some brief statement in the IRRF indicating that the team considered individualized possible contra-indications for the individual, that is, for example, that the team looked at the active problem list (e.g., how osteoporosis might affect the usage or prohibition of restraint).

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, indicator 13 might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring. Indicator 14 will also remain in active monitoring for review at the next onsite visit if it should be applicable to any restraints.			Individuals:								
#	Indicator	Overall Score	134	118	139	357	375	385			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 10/10	2/2	2/2	2/2	1/1	2/2	1/1			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Comments:											

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: monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; providing more detailed descriptions of individuals' mental status, including specific comparisons to			Individuals:								

the individual's baseline; in IPNs and IView, documenting injury assessments; and documenting respirations, even when individuals refuse other physical assessments. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	134	118	139	357	375	385			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	10% 1/10	0/2	0/2	1/2	0/1	0/2	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	30% 3/10	1/2	1/2	0/2	0/1	0/2	1/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	13% 1/8	1/2	0/1	0/2	0/1	0/2	N/A			
<p>Comments: The restraints reviewed included those for: Individual #134 on 6/27/18 at 1:25 p.m., and 8/2/18 at 6:56 p.m.; Individual #118 on 8/4/18 on 8:58 p.m., and 9/3/18 on 4:12 p.m.; Individual #139 on 6/20/18 at 4:00 p.m., and 8/21/18 on 2:59 p.m.; Individual #357 on 6/9/18 at 7:23 p.m.; Individual #375 on 6/12/18 at 8:51 p.m. (chemical), and 6/29/18 at 5:42 a.m.; and Individual #385 on 9/3/18 at 1:30 a.m.</p> <p>a. through c. For Individual #139's restraint on 6/20/18 at 4:00 p.m., the nurse performed necessary physical assessments.</p> <p>It was good to see that for all 10 restraints reviewed, nurses initiated monitoring at least every 30 minutes from the start of the restraint.</p> <p>For the following restraints, the nurses documented whether or not the individual sustained restraint-related injuries or other negative health effects: Individual #134 on 8/2/18 at 6:56 p.m.; Individual #118 on 8/4/18 on 8:58 p.m., and Individual #385 on 9/3/18 at 1:30 a.m.</p> <p>The following provide examples of problems noted:</p> <ul style="list-style-type: none"> • For Individuals who refused vital signs, nurses did not document respirations (i.e., Individual #134 on 6/27/18 at 1:25 p.m., Individual #357 on 6/9/18 at 7:23 p.m.; and Individual #375 on 6/12/18 at 8:51 p.m., and 6/29/18 at 5:42 a.m.). • Nurses properly documented mental status for only three of the restraints reviewed (i.e., Individual #139's restraint on 6/20/18 at 4:00 p.m., and Individual #375 on 6/12/18 at 8:51 p.m., and 6/29/18 at 5:42 a.m.). • For a number of the restraints reviewed, the nurses did not document skin assessments in IPNs and/or IView. • In other instances, nurses documented high or low vital signs, but did not document follow-up. • On 6/12/18, at 8:51 a.m., nursing staff administered a chemical restraint to Individual #375. A nursing IPN, dated 6/12/18 at 10:36 a.m., stated that after the restraint, the individual refused assessment three times. The nurse did not document respiratory rates, when noting that the individual's respirations were even and non-labored with no sign of respiratory distress or discomfort. The next IPN, dated 6/12/18 at 10:53 a.m., did not include vital signs or other assessment information. On 6/12/18, at 1:34 p.m., the next nursing IPN entry noted that the individual was alert and responsive, and sleeping in her bedroom. The nurse did not state to what she was alert or responsive. The 6/12/18 IView entries did not include monitoring 											

at the required frequency (i.e., for a chemical restraint, vital signs and mental status assessments every 15 minutes for the first hour, then every 30 minutes for one hour, and then ongoing for any abnormal findings). On 6/12/18 at 8:00 p.m., a nurse documented the first set of vital signs. The next set of vital signs on 6/13/18 at 12:00 a.m., included a low temperature reading, for which follow-up was not found, and did not include an oxygen saturation rate.

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: Documentation for two restraints did not have the customary entry showing date of IMRT review on IRIS form. That is, there was documentation showing that IMRT did review the restraint, but the date should also be on the IRIS documentation.					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: For the one instance reviewed by the Monitoring Team, all criteria were met for indicators 47 and 49. Moreover, good monitoring and follow-up post restraint were done. This was the case at the Center for the past two reviews, too. Therefore, indicators 47 and 49 will be moved to the category of requiring less oversight. Multiple medications were used. With documentation/rationale, that indicator can be scored positively in the future, too. It will remain in active monitoring.					Individuals:						
#	Indicator	Overall									
		375									

		Score										
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									
<p>Comments: 47-49. The above indicators applied to a chemical restraint regarding Individual #375. The Administration of Chemical Restraint: Consult and Review was completed by the psychiatrist on the day of the restraint. In this episode, three psychotropic medications, Haldol, Ativan, and Benadryl, were administered. There was documentation of psychiatry follow-up on the day of the restraint and two days after. Due to concerns regarding this individual receiving an antipsychotic medication in addition to her regularly prescribed regimen, an EKG was ordered and reviewed by the psychiatrist. This and the follow-up performed by the psychiatrist were good to see.</p>												

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.												
Summary: Overall, San Antonio SSLC continued to have most supports in place to reduce the likelihood of abuse, neglect, injuries, and incidents. In some cases, however, IDTs and incident management staff did not thoroughly look at prior occurrences and trends. This indicator remains in active monitoring.					Individuals:							
#	Indicator	Overall Score	134	129	139	375	385	380	366	317	163	178
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	82% 9/11	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
<p>Comments: The Monitoring Team reviewed 11 investigations that occurred for 10 individuals. Of these 11 investigations, seven were HHSC PI investigations of abuse-neglect allegations (two confirmed, two unconfirmed, one inconclusive, one with a finding of "other," one referred for administrative review). The other four were for facility investigations of serious injuries and a sexual incident. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.</p> <ul style="list-style-type: none"> • Individual #134, UIR 18-455, HHSC PI 46981472 merged w/46981747, inconclusive allegation of physical abuse, 5/20/18 • Individual #134, UIR 18-067, sexual incident, 8/11/18 • Individual #129, UIR 18-421, HHSC PI 46859648, confirmed allegation of physical abuse, 5/2/18 • Individual #139, UIR 18-603, HHSC PI 47393499, unconfirmed allegation of neglect, 8/15/18 												

- Individual #380, UIR 18-070, witnessed laceration, head, 8/19/18
- Individual #375, UIR 18-382, HHSC PI 46747712, allegation of physical abuse with a finding of other, 4/13/18
- Individual #385, UIR 18-353, HHSC PI 46670097, unconfirmed allegation of verbal emotional abuse, 4/2/18
- Individual #366, UIR 18-481, HHSC PI 47053781, confirmed allegation of physical abuse, reportable conduct, 5/31/18
- Individual #317, UIR 18-509, HHSC PI 47149408, clinical referral of allegation of neglect, 6/21/18
- Individual #163, UIR 18-066, discovered fracture, clavicle 8/8/18
- Individual #178, UIR 18-044, serious injury, thumb, amputation, witnessed, 4/17/18

1. For all 11 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.

For all investigations, criminal background checks and duty to report forms were completed and available for review. For seven of the 11, the investigation was regarding solely allegations of staff misconduct and, for each of these, there were no relevant individual-related trends to be reviewed. For two off the other four, the sub-indicators for trend reviews and implementation of plans were in place. For one of the other two, the UIR noted that the individual was not engaged in programming or activities and staff did note antecedents/precursors or implement the PBSP. Although it was unfortunate that these aspects were not in place, it was very good to see that the investigation went into this level of detail and description (Individual #178 UIR 18-044). For the other, supports were not effective, that is, falls continued to occur. Her IDT had not tracked and trended the cause of falls (though there were many hypotheses put forward by IDT members, such as behavior, vision, environmental hazards), but had not collected or looked at any data to determine causes, similarities, and circumstances around falls Individual #163 UIR 18-066).

There was one individual at San Antonio SSLC identified for streamlined investigations. He had a long history of making frequent (sometimes more than once a day) allegations, usually via telephone. There was appropriate documentation showing APS/HHSC PI determination of placement on the streamlined investigation list and there was documentation showing that the Center regularly reviewed this issue and had a plan in place to address (i.e., the PBSP).

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.													
Summary: Performance improved a bit since the last review. Three allegations/incidents were reported late. The HHSC PI and/or the UIR should do further examination of the circumstances surround the late reporting. This indicator will remain in active monitoring.			Individuals:										
#	Indicator	Overall Score	134	129	139	375	385	380	366	317	163	178	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by	73% 8/11	2/2	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	

DADS/facility policy.												
<p>Comments:</p> <p>2. The Monitoring Team rated eight of the investigations as being reported correctly. The other three were rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator.</p> <p>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.</p> <ul style="list-style-type: none"> For Individual #129 UIR 18-421, the allegation was made by a QIDP who was reviewing injury reports from the prior day. The nurse who treated the individual did not report it even though it was clear that the injury occurred during a check and change that should have been performed by two staff. It seemed that the nurse was not thoroughly trained/knowledgeable about reporting requirements. Also, the UIR stated that the reporter was unknown when later in the report, it showed that a QIDP was the reporter. For Individual #139, UIR 18-603, according to HHSC PI report, the incident occurred on 8/9/18, but not reported until 8/15/18. The UIR did not explore the circumstances around this. For Individual #366 UIR 18-481, the incident occurred on 5/26/18 and was reported on 5/31/18 when discovered in a video review. The alleged perpetrator was in an activity room with other individuals. There was no information in the HHSC PI report or in the UIR that addressed whether the alleged perpetrator was the only staff in the room (or if there were others). 												

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.												
<p>Summary: Staff at San Antonio SSLC consistently correctly responded to Monitoring Team questions about ANE, injuries, and reporting requirements. Therefore, indicator 3 will be moved to the category of requiring less oversight. Even so, this should continue to be a focus of the incident management program, as evidenced by the handful of late reports described above in indicator 2.</p> <p><u>Note:</u> For indicator 4, sub-indicator .2, regarding the IDT/ISP review and discussion about abuse, neglect, and injuries, did not meet criterion for some individuals. The problem was that the ISP stated that injuries and/or allegations/investigations occurred, but gave no data, summary, or indication of the outcome of investigations. The Monitor will keep indicator 4 in the category of less oversight due to the Center’s history of meeting all of the sub-indicator criteria, however, this aspect needs to be corrected in order for it to remain in this category.</p>					Individuals:							
#	Indicator	Overall Score	134	129	139	375	385	380	366	317	163	178
3	Staff who regularly work with the individual are knowledgeable	100%	Not	Not	Not	Not	Not	1/1	Not	Not	1/1	1/1

	about ANE and incident reporting	3/3	rated	rated	rated	rated	rated		rated	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: Performance improved to 100% (compared to 60% at the last review). It was good to see that San Antonio SSLC was providing immediate protections for individuals. This indicator will remain in active monitoring.					Individuals:							
#	Indicator	Overall Score	134	129	139	375	385	380	366	317	163	178
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 11/11	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments:												

Outcome 5- Staff cooperate with investigations.												
Summary:					Individuals:							
#	Indicator	Overall Score										
7	Facility staff cooperated with the investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Outcome 6- Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary: Even though an important component of one investigation was not done (Individual #385 UIR 18-353), the Center has, overall, shown good performance on indicator 9, for this and for the previous three reviews, too. Therefore, indicator 9 will be moved to the category of requiring less oversight. Indicator 10 will remain in active monitoring.					Individuals:							
#	Indicator	Overall Score	134	129	139	375	385	380	366	317	163	178

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, documentary, and testimonial), weighed, analyzed, and reconciled.	91% 10/11	2/2	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	82% 9/11	2/2	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
<p>Comments:</p> <p>9-10. For Individual #385 UIR 18-353, HHSC PI interviewed the behavior analyst regarding emotional harm to the individual. But, HHSC PI did not interview the alleged perpetrators. It is also of concern that the facility, in its own follow-up, did nothing to determine if the two alleged perpetrators actually said what was reported they said. Nothing in the UIR reflected any investigatory follow-up. Thus, not all relevant evidence was collected, weighed, etc.</p> <p>10. For Individual #163 UIR 18-066, the facility investigation concluded that the injury resulted from a fall (undetermined date or location). The investigation did not attempt to validate the degree to which preventive measures (e.g., PBSP, PNMP) were implemented/observed in the days preceding the discovery of the injury (in contrast to the similar work done on investigation Individual #178 UIR 18-044). This level of analysis may have yielded clues as to whether the event that caused the fracture was accidental from a fall, accidental from program implementation, or the result of neglect.</p>												

Outcome 7- Investigations are conducted and reviewed as required.												
Summary: About one-quarter of the investigations did not meet the timeline requirement. This has been an ongoing problem for the Center. A priority area for the Center and the IM department is the conduct of thorough reviews of investigations to ensure its completeness and accuracy. These two indicators will remain in active monitoring.					Individuals:							
#	Indicator	Overall Score	134	129	139	375	385	380	366	317	163	178
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).	73% 8/11	1/2	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the <u>investigation</u> was thorough and complete and (2) the <u>report</u> was	36% 4/11	1/2	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1

accurate, complete, and coherent.											
<p>Comments:</p> <p>12. Three investigations were not completed within 10 calendars (or had proper extensions completed). Two of these were facility investigations and one was an HHSC PI investigation. This indicator looks at both types of investigations.</p> <ul style="list-style-type: none"> For Individual #134 UIR 18-067, the incident occurred on 8/11/18. The investigation was completed on 8/22/18 (i.e., 11 days). For Individual #375 UIR 18-382, the incident occurred on 4/13/18 and the investigation was completed on 8/14/18. The documentation did not include the various customary review dates. There were dates of 5/3/18, 5/8/18, 6/13/18, and 8/22/18. The State submitted a comment in response to the draft version of this report that the case was initially closed on 5/3/18, but then re-opened for additional information due to an appeal, and was then closed on 8/14/18. The State wrote that HHSC PI does not require extension notifications to the Center when a case is investigated on appeal. The Settlement Agreement, however, requires that investigations be completed timely and that extensions be completed. Further, the submitted dates indicated that there were two months with no extensions (June to August). For Individual #317 UIR 18-509, the date entries were not at the end of the UIR, thus, the Monitoring Team could not determine whether the timeline requirement was met for this investigation. <p>13. Supervisory review did not detect the missing or problematic aspects of seven of the 11 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.</p> <p>This is a priority area for San Antonio SSLC's incident management department. The department might benefit from some guidance from State Office regarding the conduct of reviews of investigations.</p>											

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.											
Summary: San Antonio SSLC corrected the problems it had with audits of significant injuries (indicator 14). On the other hand, non-serious injury investigations were not conducted for three individuals when they should have been (indicator 15). Given the Center's long history of conducting non-serious injury investigations correctly, the Monitor will leave this indicator in the category of requiring less oversight.					Individuals:						
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided										

enough information to determine if an abuse/neglect allegation should have been reported.	
Comments:	

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.													
Summary: There was much improvement in the identification of recommendations in investigations. With continued improvement, indicator 16 might be moved back into the category of requiring less oversight after the next review. Most, but not all, recommendations were implemented. These indicators will remain in active monitoring.					Individuals:								
#	Indicator	Overall Score	134	129	139	375	385	380	366	317	163	178	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	75% 6/8	2/2	1/1	N/A	0/1	0/1	N/A	1/1	N/A	1/1	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	75% 3/4	0/1	1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	75% 3/4	1/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Comments: 16. For two investigations (Individual #375 UIR 18-352, Individual #385 UIR 18-353), there were no recommendations, but based upon the content of the incident and investigation reports, there should have been. 17. For Individual #134 UIR 18-455, there was a recommendation for staff training, but no documentation to show that it happened. There were four 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 #134 UIR 18-455, there was a recommendation to review and modify the PBSP, but no documentation to show that it happened.													

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										
<p>Comments:</p> <p>19. Four of the required data sets were not being tracked and trended: staff, location, date/time, and cause.</p> <p>20-23. There was little analysis of the available data regarding identifying any aspects worthy of further exploration, or any explanation that this analysis was done and there was nothing further to explore. For example, the tier 1 document .19 showed 19 confirmed allegations involving 25 staff. This is an example of an aspect of the data that might warrant further exploration.</p> <p>Each incident management report included (at the end) a section "Efforts to Reduce Identified Trends." These were general statements (e.g., ongoing inservicing, staff will be adjusting to schedules, ensure staff always have supplies on hand) that did not use data to articulate a problem, identify specific actions intended to improve the problem, and the use data to measure whether or not improvement occurred.</p>												

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.												
Summary: These indicators will continue in active oversight.					Individuals:							
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178	
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A	
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	Not applicable (N/A)										

Comments: a. As discussed in previous reports, 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. 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.

Based on documentation submitted, on 5/7/18, Individual #331 had a dental appointment off campus that required the use of general anesthesia (GA). However, in response to the Monitoring Team’s request for documents to complete these indicators, the Center submitted documents stating the individual did not receive this service, so no further documentation was submitted.

The cardiologist cleared Individual #352 for TIVA. This evaluation only addressed the individual’s cardiac status. There was no evidence that a thorough perioperative evaluation was done. In addition, the cardiac consult submitted was essentially blank, but noted the electrocardiogram (EKG), completed on 2/26/18, was normal. Prior to the use of TIVA or GA, individuals should undergo thorough perioperative evaluations that are consistent with current nationally acceptable guidelines. A consult that fails to include basic health information does not meet any reasonable and acceptable standard of care.

For Individual #352, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and nurses monitored the individual’s vital signs in accordance with the requirements of the policy.

b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for dental procedures.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: a. Based on the documentation provided, during the six months prior to the review, 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: ISPs documented that IDTs were discussing and reviewing PTS for some individuals. For most of individuals, some type of plan was developed and implemented to potentially reduce future need for PTS, though there was little/no review of progress. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	362	129	118	139	357				
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	60% 3/5	0/1	0/1	1/1	1/1	1/1				
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	80% 4/5	1/1	0/1	1/1	1/1	1/1				
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	75% 3/4	1/1	No plan	0/1	1/1	1/1				
4	Action plans were implemented.	100% 4/4	1/1	No plan	1/1	1/1	1/1				
5	If implemented, progress was monitored.	0% 0/4	0/1	No plan	0/1	0/1	0/1				
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/4	0/1	No plan	0/1	0/1	0/1				
<p>Comments:</p> <p>1-6. This outcome and its indicators applied to Individual #362, Individual #129, Individual #118, Individual #139, and Individual #357.</p> <p>1. Available ISPAs provided evidence that Individual #118, Individual #139, and Individual #357's IDTs discussed behaviors observed during the procedure, other supports and interventions provided, additional supports or interventions that could be provided for future appointments, and the risk-benefit of the procedure without PTS versus with PTS. Additionally, there was documentation of informed consent. Available documentation for Individual #129's ISPAs, however, only had evidence of behaviors observed during the procedure, and informed consent, while Individual #362's available ISPAs had evidence of only informed consent.</p> <p>2. Individual #362, Individual #118, Individual #139, and Individual #357's IDT developed action plans to reduce the usage of TIVA</p> <p>3. Individual #362, Individual #139, and Individual #357's treatment strategies were based upon the hypothesized cause, in their ISPA, and written as a SO or SAP. Individual #118's treatment strategies were not written as a SAP, SO, or IHCP.</p> <p>4. There was evidence that action plans were implemented.</p> <p>5-6. There was no documentation of data reviews on progress of these treatment strategies for any individuals.</p>											

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.										
Summary: These indicators will continue in active oversight.					Individuals:					
#	Indicator	Overall Score	4	18	233	199				
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1				
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1				
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1				
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1				
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1				
<p>Comments: a. Since the last review, five individuals died. The Monitoring Team reviewed four deaths. At the time of the Monitoring Team’s document request, the Center’s review and follow-up activities for Individual #294 were not complete. Causes of death were listed as:</p> <ul style="list-style-type: none"> • On 4/13/18, Individual #4 died at the age of 67 with causes of death listed as septic shock with multi-organ failure, and pancytopenia. • On 6/13/18, Individual #18 died at the age of 56 with causes of death listed as cardiac arrest, sudden unexpected death in epilepsy (SUDEP), and epilepsy. • On 6/16/18, Individual #233 died at the age of 68 with causes of death listed as recurrent malignant melanoma to the left lower extremity with distant metastasis to the lung and liver. • On 8/24/18, Individual #199 died at the age of 64 with preliminary causes of death listed as sepsis, respiratory failure, and pancreatitis. • On 9/27/18, Individual #294 died at the age of 74 with cause(s) of death pending. 										

b. through d. A number of problems were noted with regard to the Center's review of individuals' deaths. For example:

- Evidence was not submitted to show the Facility conducted thorough reviews of nursing care, or an analysis of medical/nursing reviews to determine additional steps that 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.
- Mortality reviews should identify opportunities for quality improvement, including any situation where the individual's care is adversely influenced by gaps in standard processes. The gap does not have to be the cause of death. There were a number of recommendations related to process deficiencies that were rejected because the gap was not considered to be related to the death. For example, the external reviewer noted that there was an inadequate plan related to the need for future dialysis. IDTs should assess the individual's renal function and make plans long in advance of the anticipated need for dialysis, so this was another valid recommendation that the committee should have addressed. Addressing such gaps would have the potential of improving supports for other individuals.
- Similarly, Quality Improvement Death Reviews of Nursing Services (QIDRs) included statements such as "no nursing recommendations that directly contributed to the cause of death." Again, mortality reviews should provide an opportunity to review the overall care provided to the individual, and identify any gaps in protections, services, and supports.
- For Individual #18, the Clinical Death Review included no discussion related to the appropriateness of anti-epileptic drug (AED) polypharmacy or if neurological care was optimal. Examples of questions the committee should have asked included: Did the individual have a refractory seizure disorder, and if so, was he evaluated by the epileptologist? Was there appropriate follow-up for the obstructive sleep apnea? Was the treatment adequate? Was the continuous positive airway pressure (CPAP) machine checked periodically (i.e., based on the nursing corrective action plan, there was a problem)? Was there follow-up with a sleep specialist to ensure that the treatment was optimized, pressures were appropriate, and treatment was effective? None of these questions were addressed in the clinical death review. If the machine was not maintained properly, this could be indicative of the Center not having the appropriate procedures in place, and this gap in the process could impact other individuals.
- For Individual #199, the Clinical Death Review noted that the PCPs would participate in an in-service training related to pancreatitis. The Clinical Death Review provided no documentation of why this was necessary. If there was evidence that the management of pancreatitis was not adequate, the committee should have discussed the specific issues. In its comments on the draft report, the State provided the following in an attempt to provide clarification: "Pancreatitis review was included in the external reviewer's report. As this is an unusual cause of death, the Up To Date review article was recommended for the physicians to review current standards." This did not resolve the Monitoring Team's concern. Pancreatitis is not an unusual diagnosis, and so it remained unclear they the training was needed. The Clinical Death Review also stated: "it was also concerning that earlier medical evaluation, while not effecting [sic] the outcome would possibly have led to an earlier diagnosis." If there was a delay in the diagnosis of pancreatitis, the review should have clearly stated this, and then included recommendations to address the issue.
- For Individual #4 and Individual #18, the QIDRs included a recommendation stating: "Annual Nursing Assessment and Quarterly Assessments, analysis section could be improved." However, the QIDRs did not provide specifics or contain examples of findings to explain the need for this recommendation.
- For Individual #18, the QIDR included the following statement: "AEDs [automated external defibrillator] – see the placement of the pads from the diagram." From the documentation provided, the relevance of this statement to the individual's care was

unclear.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: “ensure the individual’s pre needs [sic] are discussed. The QIDP will discuss with the QIDP Coordinator” did not ensure that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not individuals’ pre-needs (i.e., not clear to what this referred, given the lack of rationale in the death review for this recommendation) were identified and addressed.

The Center’s mortality recommendation tracking log often indicated that recommendations were “closed,” without providing the date of closure.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	ADRs are reported immediately.	100% 1/1	N/A	1/1	N/A	N/A	N/A	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 4/10/18, nursing staff reported to the PCP that Individual #134 was lethargic. It should be noted that at the time of admission, the individual’s mother, who is very involved in her care, reported that lethargy and other issues were noticed a few weeks after the Depakote was started. On 4/20/18, the neurologist made a recommendation to titrate the medication to extinction.											

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: If the Center sustains its progress with regard to the completion of clinically significant DUEs, after the next review, Indicator a might move to the category requiring less oversight. At this time, these indicators will continue in active oversight.			Individuals:								
#	Indicator	Score									
a.	Clinically significant DUEs are completed in a timely manner based on the	100%									

	determined frequency but no less than quarterly.	2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	N/A
<p>Comments: a. and b. In the six months prior to the review, San Antonio SSLC completed two DUEs, including:</p> <ul style="list-style-type: none"> • A DUE on the use of calcium supplementation in individuals fed with enteral formula that was presented to the Pharmacy and Therapeutics (P&T) Committee in June 2018, for which follow-up was not yet due; and • A DUE on fluoroquinolone utilization that was presented to the P&T Committee in September 2018, 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, 27 of these indicators were in the category of requiring less oversight. For this review, three other indicators were moved to this category, in ISPs, psychiatry, and medical.

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

Most IDTs identified needed assessments, but most did not obtain all of those needed assessments.

In behavioral health, annual behavioral assessments, functional assessments, and PBSPs continue to be consistently timely and complete.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. As a result, for the great majority of the risk ratings reviewed, it was not clear that the risk ratings were accurate.

On a positive note, for this review and the previous two reviews, Medical Department staff completed the medical assessments reviewed in a timely manner. As a result, the related indicator will be placed in the category requiring less oversight.

Center staff should continue to improve the quality of the medical assessments, with particular focus on, as applicable, family history, childhood illnesses, and plans of care for each active medical problem. More work was needed, but some improvement was noted with regard to PCPs completing quality interval medical reviews.

The timely completion of annual dental exams to coincide with individuals' ISP meetings has not improved despite past reports identifying this problem. The Center should also continue its focus on improving the quality of dental exams and summaries.

For all nine individuals reviewed, nurses completed timely annual or new-admission nursing reviews and physical assessments. Some problems were noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments.

The quality of nursing assessments was an issue. For example, 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 some instances, when individuals experienced changes of status, nurses completed assessments consistent with current standards of practice, which was good to see.

Improvement is still needed with regard to timely referral of individuals to the PNMT. Generally, once individuals were referred, the PNMT completed timely reviews, and completed full assessments, when needed. It was good to see that for one individual, the PNMT conducted a quality comprehensive assessment. Unfortunately, the other PNMT assessment reviewed was of poor quality.

As indicated in the last report, a significant issue was that Center staff had not followed the current guidelines for considering when an OT/PT comprehensive assessment 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 sufficiently justified why an update met the individual's needs. The assessments reviewed needed considerable improvement.

As indicated in the last report, a significant issue was that Center staff had not followed the current guidelines related to when a communication comprehensive assessment should be repeated. For a number of individuals reviewed, the three-year mark had passed, and Speech Language Pathologists (SLPs) had not completed a new comprehensive assessment, or provided sufficient clinical justification for why an update met the individual's needs. As also indicated in the last report, significant work is needed to improve the quality of communication assessments.

Individualized Support Plans

Overall, QIDPs were knowledgeable regarding the needs and status of supports for individuals and had made good progress in documenting the status of services through the monthly review process. DSPs were also, for the most part, familiar with support needs, preferences, and strengths of individuals in their care.

The number of ISP personal goals that met criteria for individuality, decreased since the last review. The QIDP department had implemented several new processes that should lead to improvements in the ISP process, particularly the new PSI peer review process.

Few action plans/goals were regularly implemented and little progress had been made towards goals. ISPs still lacked action plans that would support accomplishment of goals. Training opportunities that would lead towards greater independence and a more meaningful day were still extremely limited.

Unit directors reported that they wanted to be more involved in supporting action plan implementation and goal achievement. This interdisciplinary approach will be good to see occurring.

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.

Some improvement was noted with regard to ISPs/IHCPs defining the frequency of interval medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines.

With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs.

The facility had two full time psychiatrists, a psychiatry assistant, and a nurse. It was good to see a committed, stable psychiatry staff team at San Antonio SSLC.

The psychiatry department continued to work on identifying psychiatric indicators. Once the indicators are determined and baseline rates established, goals can be developed. A good interdisciplinary collaborative relationship existed between psychiatry and behavioral health. For instance, psychiatrists participated in the development of the PSPs and PBSPs. Further, the behavioral health department and psychiatry department will be collaborating in the identification of psychiatric indicators, defining them in observable terminology, and developing reasonable data recording systems.

There was improvement in the content of the medication consent forms and documentation since this past June, such as including a risk/benefit discussion and individualized alternatives to pharmacotherapy.

All SAPs were consistently measurable and based on assessment results. Although only a few SAPs contained all the components necessary for optimal learning, all SAPs consistently contained the majority of components.

The majority of SAPs were judged as not practical or functional because they were not clearly related to the individual's vision statement and/or the SAPs were compliance plans rather than the teaching of new skills.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: Performance, in terms of the number of personal goals that met criteria, decreased since the last review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	134	129	118	357	352	36			
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	5/6	3/6	1/6	1/6	3/6	1/6			
2	The personal goals are measurable.	0% 0/6	5/6	2/6	1/6	0/6	1/6	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	2/6	0/6	0/6	0/6	1/6	0/6			
<p>Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #134, Individual #357, Individual #118, Individual #129, Individual #352, and Individual #36. 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.</p> <p>1. The ISP relies on the development 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.</p> <p>IDTs were struggling to develop good vision statements for individuals. This led to the development of goals with no clear purpose or priority for the individual. Rarely were goals aspirational. In particular, work and day goals were not meaningful or functional. Rather than being aspirational or providing opportunities to learn new skills, day goals typically related to compliance with attending solely the on-campus day or work sites.</p> <p>None of the six individuals had individualized goals in all six goal areas. Therefore, none had a comprehensive set of goals that met criterion.</p> <p>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, 14 of 36 personal goals met criterion for this indicator. This was a decrease from</p>											

22 at the last review.

The IDTs might make better use of the ISP preparation meeting, such as using the meeting to discuss how the IDT can use the subsequent three months to explore various aspects of supports and services to then include in the annual ISP. Personal goals do not need to be identified at the ISP preparation meeting. See comments regarding Individual #118's ISP preparation meeting in indicator 17 below.

Goals that met criterion were:

- Individual #134's goals for recreation/leisure, relationships, day programming, greater independence, and living options.
- Individual #357's goal for recreation/leisure.
- Individual #118's goal for relationships.
- Individual #129's goals for recreation/leisure, relationships and greater independence.
- Individual #352's goals for recreation/leisure, greater independence, and living options.
- Individual #36's greater independence goal.

Although IDTs had created the above goals (that were more individualized and based on known preferences), few had specific teaching strategies to ensure staff were implementing them and measuring success consistently, additionally, few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The facility needs to focus on barriers that are preventing individuals from achieving their goals and develop plans to address those barriers.

Unit directors reported that they wanted to be more involved in supporting action plan implementation and goal achievement. This interdisciplinary approach will be good to see occurring.

2. Of the 14 personal goals that met criterion for indicator 1, 10 also met criterion for measurability,

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. Three 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. These were Individual #134's goals for relationships and greater independence and Individual #352's goal for greater independence.

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 Center. 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.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: Overall, scores remained low for this set of indicators. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	134	129	118	357	352	36			
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	1/6	0/6	0/6	1/6	1/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	50% 3/6	0/1	0/1	0/1	1/1	1/1	1/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	50% 3/6	0/1	1/1	0/1	0/1	1/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	2/6	0/6	0/6	0/6	1/6	0/6			
<p>Comments:</p> <p>8. Ten 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.</p>											

Three of the goals had action plans that were likely to lead to the accomplishment of the goal. Individual #129, Individual #352, and Individual #36's action plans to supported their greater independence goal had reasonable action plans to support these goals.

For the most part, though, IDTs were not developing action steps that would lead to measurable progress towards goals. Although the facility acknowledged that IDTs needed additional training on developing action plans to support goals at the last review, there had been no identifiable progress in developing action plans to support goals.

Skill acquisition programs did not include enough information to ensure that staff could consistently implement them and determine what progress was made. Most of the action plans were written as service objectives and did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress.

9. Three of the ISPs had action plans that integrated preferences and opportunities for choice. Individual #357, Individual #352, and Individual #36's action plans did minimally provide opportunities and action plans were based on identified preferences.

IDTs were generally not identifying preferences in a way that might guide the development of activities that would offer opportunities to learn new skills and build on developing a plan for meaningful days. For the most part, ISPs listed general preferences related to food, music, tv, and activities routinely offered at the facility. Opportunities to make meaningful choices were limited, for the most part. Expanding choices may result in discovering new preferences.

10. None of the 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 rarely included in action plans in any substantial way.

A new peer support project was initiated during the onsite week. It was being run by the Texas Advocates agency and involved the eventual hiring of 25 peer support specialists. These were to be individuals who lived in the community to be paid support mentors for about individuals who lived at the San Antonio SSLC (and Austin SSLC, too). Each peer support specialist was expected to be involved with about 10 individuals. It may be possible to incorporate some of this into individuals' ISPs.

11. Three of the ISPs met criterion for this indicator to support the individual's overall independence. This included:

- Individual #129's action plans to independently turn on his TV and activate a switch to turn on his music.
- Individual #352's action plan to independently prepare his snack.
- Individual #36's action plan to use a switch to turn on his music.

Assessments and interviews indicated that many of the action plans were compliance plans written for skills that the individual could already complete independently.

12. None of the ISPs integrated strategies to minimize risks in ISP action plans. While risks were addressed through action plans included in the IHCP, supports were not integrated into other action plans when relevant, and risks were not always identified by the IDT. Rarely were SAPs written to provide staff with strategies for implementing plans and, when SAPs were written, they did not

include specific mobility, behavioral, and safe eating supports.

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. Some examples of this lack of integrated supports included:

- Individual #134's IDT did not consider her risk of metabolic syndrome due to her medication regimen. Her behavioral needs were not fully integrated in to planning for day programming and employment.
- Recommendations from Individual #357's communication assessment had not been fully integrated into her ISP. Thus, staff were using a variety of communication methods with her rather than concentrating on strengthening her communication skills. She would benefit from an integrated assessment that takes into consideration her neurological, psychiatric, medical, and behavioral needs.
- Individual #129's mobility and occupational therapy supports had not been integrated into his day program goals. During observation, it was noted that he was unable to functionally use his switch to independently turn on his music. Staff must bring him the switch and hold it for him to use it.

14. Meaningful and substantial community integration action plans were absent from the ISPs for these individuals, with no specific, measurable action plans for community participation that promoted any meaningful integration.

Individuals made frequent trips into the community, but were rarely given opportunities to utilize community resources that might support them to be more independent and integrated into the community. Individuals did not have 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. ISPs included action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #134's had a goal to work in the community, however, her action plans did not support this goal. Day and work opportunities were particularly limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting.

Training opportunities were limited and rarely individualized. Individuals had few opportunities to learn new skills and experience new things. Individual #134, Individual #357, and Individual #36 did not spend a majority of their day outside of their homes engaged in meaningful programming.

16. For the most part, 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. During observations, activities were rarely functional and did not provide opportunities to experience new things and learn new skills. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests. Although more individuals were out of the homes and involved in day programming, which was good

to see, many individuals were not engaged in functional training.

- Individual #134 had two SAPs for day programming. One she had completed and the other was not based on preferences or skill building.
- Individual #129 had one SAP to play music during day programming. Although this might lead to greater independence, there was no evidence that this might lead to a more meaningful day program. During observations at the day program, Individual #129 was not meaningfully engaged.
- Individual #357 had two action plans related to work. She routinely refused to participate in her action plans. The IDT had not explored other work options that might be based on her preferences and would be more meaningful to her.
- Individual #118's action plans related to work appeared to be based on compliance rather than learning new skills.
- Individual #352's action plans related to work were not functional and did not focus on developing new work skills.
- Individual #36 did not attend day programming outside of his room.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Goals were not consistently implemented, and IDTs did not address barriers to implementation. A review of ISP preparation documents indicated that some goals that either had not been implemented or the individual failed to make progress were continued from the previous ISP without addressing barriers. For example, Individual #118 had a vocational goal to earn enough money at the workshop to purchase a game for his Leap Frog system. He had not completed the goal because staff had not followed through to help him purchase the game even when he had earned enough at the workshop to do so. The IDT agreed to continue the goal without addressing barriers to progress at his ISP preparation meeting.

18. Action plans did not describe detail about data collection and review, in almost all cases. 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, not individualized, and, in most cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented. The three action plans that did meet criteria were Individual #134's action plans for relationships and greater independence and Individual #352's action plans for greater independence.

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

Summary: Deeper IDT work on most integrated setting topics was needed, especially as evidenced at annual ISP meetings observed by the Monitoring Team. No individuals transitioned during the nine-month review period, though 15 were in the active referral process at the time of the onsite week. ISPs did, however, include an overall decision of the entire IDT. This was the case for the previous two reviews, too (with one exception). **Therefore, indicator 22 will be moved to the category of requiring less oversight.** The other indicators (except for indicators 22 and 24) will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	134	129	118	357	352	36			
19	The ISP included a description of the individual's preference for	67%	1/1	1/1	1/1	1/1	0/1	0/1			

	where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	4/6									
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	N/A	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	0/1	1/1	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.	50% 3/6	1/1	0/1	0/1	1/1	1/1	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).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/4	N/A	0/1	0/1	0/1	N/A	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			
<p>Comments:</p> <p>19. Four ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT.</p> <ul style="list-style-type: none"> • Individual #134 had recently lived in the community and was familiar with living options. She told the IDT that she wanted to live in the community near her mother. • Individual #357 had also recently lived in the community, so was familiar with living options. Her ISP included her preferences for living environment based on staff knowledge, including a home near her mother, a nice patio area, near a park, with big windows. • Individual #118 was somewhat familiar with living options. The ISP noted that he expressed a desire to live in the community in a group home. 											

- Individual #352 indicated that he would like to live in a group home in the community.
- Individual #129 and Individual #36 were unable to express their preferences. Both had lived at the facility for over 30 years. IDT members did not document their known preferences for living environment based on what they knew about each individual.

20, 25, and 27. The Monitoring Team attended two annual ISPs during the onsite week (Individual #119, Individual #236). The living options discussions lasted for about two minutes each. There was no discussion of preferences, barriers, or plans to address barriers. The living options discussion provides an opportunity to think about most integrated settings. Even if the individual is not going to be referred for transition, the discussion can lead to new ideas about supports and services.

21. Three ISPs included the opinions and recommendation of the IDT’s staff members.

- Individual #118’s ISP noted that behavior was a barrier to living in the community, however, did not include the input from his psychiatrist or behavior analyst.
- Individual #352’s nursing assessment did not include a recommendation regarding living options and his behavioral assessment was not submitted prior to the ISP meeting for team review.
- Individual #36’s medical and behavioral assessments were not submitted prior to his annual ISP meeting for team review. His PT assessment noted that he could not live in the community and did not recommend placement, but did not include a justification for the recommendation.

22. All ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.

23. Three of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. These were Individual #134, Individual #357, and Individual #352.

26. Two of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified. These were Individual #357 and Individual #352.

28. Four or four individuals did not have individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs. This was not scored for Individual #134 and Individual #352 because the IDT did not identify a need for further education either for them or their LARs.

29. None of the individuals had been referred to the community.

Outcome 5: Individuals’ ISPs are current and are developed by an appropriately constituted IDT.										
Summary: Implementation of ISPs, and participation by all team members needed improvement. Though this latter item scored better than ever before. These three indicators will remain in active monitoring.					Individuals:					
#	Indicator	Overall	134	129	118	357	352	36		

		Score									
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.										
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).	67% 4/6	0/1	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.	50% 3/6	1/1	1/1	0/1	0/1	1/1	0/1			

Comments:

32. Documentation was not submitted that showed that action plans were implemented within a timely basis for any of the individuals.

33. Four individuals attended their ISP meetings. Individual #134's ISP indicated that she declined to attend her meeting. Individual #352 chose to work during his meeting. Perhaps in the future, Individual #352's IDT could schedule his meeting when he isn't working.

34. Three of the individuals had an appropriately constituted IDT (Individual #134, Individual #129, Individual #352), based on the individual's strengths, needs, and preferences, who participated in the planning process.

- Individual #357 and Individual #36's primary care physician did not attend the ISP meeting. Both had complex medical needs.
- Individual #118's LAR did not attend his meeting.

Overall, QIDPs and other team members had little expectation for growth or greater independence. The IDT members were not tracking specific progress towards goals or addressing barriers when individuals were not making progress.

IDTs need a better understanding of the ISP process and how to develop a good vision statement, then how to support individuals to achieve that vision.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Most IDTs identified needed assessments, but most did not obtain all of those needed assessments. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	134	129	118	357	352	36			
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.	83% 5/6	1/1	1/1	0/1	1/1	1/1	1/1			

36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	33% 2/6	0/1	1/1	0/1	1/1	0/1	0/1			
<p>Comments:</p> <p>35. For five individuals, IDTs 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.</p> <p>Individual #118's IDT did not recommend an updated physical therapy assessment (last completed in 2014), an occupational therapy assessment (last completed in 2013), or a communication assessment (last completed in 2015). He had identified needs in all three areas.</p> <p>36. Four IDTs did not arrange for and obtain all needed, relevant assessments prior to the IDT meeting.</p> <ul style="list-style-type: none"> • Individual #134's annual medical assessment was submitted late and her FSA was not complete. • Individual #118's vocational/sensory assessment and behavioral assessment were submitted late. • Individual #352's last behavioral assessment was completed on 5/22/17. • Individual #36's medical and behavioral assessments were submitted late. <p>Without relevant assessments for the IDT to review, it is unlikely that comprehensive supports and services were developed, and all risks were addressed.</p>											

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	134	129	118	357	352	36			
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			
<p>Comments:</p> <p>37. IDTs met routinely to review supports, services, and serious incidents. This was good to see, however, reliable and valid data were rarely available to guide decision-making. IDTs did not routinely revise goals when progress was not evident.</p> <p>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.</p>											

For the most part, monthly reviews were routinely submitted on time and included a cursory review of all services. The consistent completion of the QIDP monthly reviews was good to see, however, they included little meaningful information regarding progress towards goals and efficacy of supports. When additional assessments were recommended throughout the ISP year, it was often not apparent that the IDT obtained those assessments, reviewed any resulting recommendations, and/or implemented changes to supports when recommended.

Some QIDP monthly reviews included data for some action plans, but rarely 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.

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 substantially 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	357	134	347	247	331	352	36	370	178
a.	The individual’s risk rating is accurate.	6% 1/18	0/2	1/2	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.	89% 16/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #357 – constipation/bowel obstruction, and seizures; Individual #134 – choking, and weight; Individual #347 – circulatory, and osteoporosis; Individual #247 – respiratory compromise, and constipation/bowel obstruction; Individual #331 – aspiration, and gastrointestinal (GI) problems; Individual #352 – infections, and constipation/bowel obstruction; Individual #36 – respiratory compromise, and GI problems; Individual #370 – falls, and cardiac disease; and Individual #178 – dental, and skin integrity].

a. The IDT that effectively used supporting clinical data, and used the risk guidelines when determining a risk level was for Individual #134 – choking.

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. Most of the individuals did not have changes of status in the risk areas reviewed that necessitated review of the risk ratings. However, for the two risk areas for which such review and revisions should have occurred, IDT did not review the IRRFs, and make changes, as appropriate. These included the following risk areas: Individual #370 – falls, and Individual #178 – skin integrity.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.															
<p>Summary: At San Antonio SSLC, there was progress in many of the sub-indicators of each of the indicators in this outcome. This is evident in the 1/2 scores in many of the individual scoring boxes below. Specifically, San Antonio SSLC made progress in that, for most individuals, psychiatric indicators for reduction were identified in one or more documents and the indicators were consistently identified. There was a need for the indicators to be defined in observable terminology. Regarding indicators for increase (i.e., positive/desirable behaviors that indicate the individual’s condition, or ability to manage the condition is improving), there remained a need for these indicators to be identified in keeping with the individual’s diagnoses. The psychiatry team at the Center appeared to have a good understanding of these indicators (i.e., psychiatric indicators, goals, documentation, data) and had a plan to continue to move forward. These indicators will remain in active monitoring.</p>					Individuals:										
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385				
4	Psychiatric indicators are identified and are related to the individual’s diagnosis and assessment.	0% 0/9	0/2	0/2	1/2	0/2	1/2	0/2	1/2	0/2	0/2				
5	The individual has goals related to psychiatric status.	0% 0/9	0/2	0/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2				
6	Psychiatry goals are documented correctly.	0% 0/9	0/2	0/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2				
7	Reliable and valid data are available that report/summarize the individual’s status and progress.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2				
<p>Comments: The scoring in the above boxes has a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase.</p>															

Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

At San Antonio SSLC, there was progress in many of the sub-indicators.

4. Psychiatric indicators:

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

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 measured via recordings of occurrences of indicators directly observed by SSLC staff. Another way is to use psychometrically sound rating scales that are designed specifically for the psychiatric disorder.

The Monitoring Team looks for:

- a. The individual to have at least one psychiatric indicator related to the reduction of psychiatric symptoms and at least one psychiatric indicator related to the increase of positive/desirable behaviors that indicate the individual's condition (or ability to manage the condition) is improving. The indicators cannot be solely a repeat of the PBSP target behaviors.
- b. The indicators need to be related to the diagnosis.
- c. Each indicator needs to be defined/described in observable terminology.

4a. San Antonio SSLC showed progress in this area in that all nine individuals had one or more indicators related to the reduction of psychiatric symptoms. This was very good to see. On the other hand, none of the individuals had psychiatric indicator for increase. Developing those, however, in discussions with psychiatry, was a future endeavor.

4b. Similarly, for eight of the nine individuals, the psychiatric indicator for decrease was related/relevant to the psychiatric diagnosis. For example, Individual #385 had diagnoses that included Bipolar Mood Disorder with psychotic features and the identified indicator was rapid mood fluctuations from crying to laughing to angry. For Individual #357, Individual #380, and Individual #139, the psychiatric indicators identified were (appropriately) similar to those identified as target behaviors by behavioral health staff for the

PBSPs. In another example, regarding Individual #118, psychiatric diagnoses included Attention Deficit Hyperactivity Disorder, Psychosis not otherwise specified, Bipolar Mood Disorder, and Oppositional Defiant Disorder Psychiatric and the psychiatric indicators were aggression, property destruction, and rapid mood fluctuations from crying to laughing to angry. Again, there were not yet psychiatric indicators for increase.

4c. For three individuals, the psychiatric indicators were defined/described in observable terminology. In general, there was a need for improvement with regard to the definition/description of psychiatric indicators. The psychiatrists indicated that they had been involved in the development of psychiatric support plans and, via this exercise, were developing and defining psychiatric indicators. For example, Individual #129 had appropriate defined indicators regarding a diagnosis of Bipolar Mood Disorder documented in the psychiatric support plan. Moreover, during the onsite week, the psychiatrists and behavioral health services director worked out a plan to collaborate on the development/definition of psychiatric indicators. This cross-discipline plan was good to see.

None of the individuals had psychiatric indicators for increase in positive/desirable actions identified. To meet this part of the criteria, there should be a rationale about how the positive/desirable action relates to the diagnosis when the action it is not immediately evident.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for three individuals. For psychiatric indicators for increase, the criteria were not met for any of the individuals.

5. Psychiatric goals:

The Monitoring Team looks for:

- d. A goal is written for the psychiatric indicator for reduction and for increase.
- e. The type of data and how/when they are to be collected are specified.

At San Antonio SSLC, there were goals written regarding psychiatric indicators for reduction for two individuals, Individual #139 and Individual #380. Goals included the psychiatric indicator and a criterion (sub-indicator d). There were no notations regarding what type of data were to be collected (sub-indicator e). However, given that these indicators were identical to the behavioral health PBSP target behaviors, it could be assumed that the indicators would be documented in care tracker (and therefore, were scored positively). Again, as the purpose of the psychiatric indicator is to determine an individual's symptom experience, a mixture of individually-defined indicators with goals (and the use of rating scales, if desired) could be considered. As there were no indicators identified for increase, there were no goals written for increase (i.e., 5d-e). Thus, both indicators were met for two individuals for indicators for reduction.

6. Documentation:

The Monitoring Team looks for:

- f. The goal to appear in the ISP in the IHCP section.
- g. Over the course of the ISP year, goals are sometimes updated/modified, discontinued, or initiated. If so, there should be some commentary in the documentation explaining changes to goals.

At San Antonio SSLC, psychiatric indicators/goals for reduction were incorporated into the Center's overall documentation system, the

IHCP for Individual #139 and Individual #380. These goals were identical to the behavioral health target behaviors and were included as part of the behavioral health tracking of the behavior support plan. There were no goals written for psychiatric indicators for the other individuals in the review group.

7. Data:

Reliable and valid data need to be available so that the psychiatrist can use the data to make treatment decisions. Data are typically presented in graphic or tabular format for the psychiatrist. Data need to be shown to be reliable. Reliability assessments are often done by behavioral health services, residential, or psychiatry staff. In addition to using data regarding psychiatric goals/indicators, psychiatrists often utilize behavioral health services target/replacement behavior data as supplemental information when making treatment decisions.

At San Antonio SSLC, data were reported for psychiatric indicators for two of the nine individuals. Review of psychiatric documentation revealed that data provided were regarding behavioral health target symptoms, and there were no data noted regarding specific psychiatric indicators. In addition, data documented in the psychiatric clinical documentation were generally stale, as they were only provided through the end of the month prior to the clinical encounter. The ongoing collection and presentation of reliable data is an area of focus for the psychiatry department. Likely, maintaining this will require ongoing collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center’s ADOP. This will be the case as San Antonio SSLC moves towards further individualizing psychiatric indicators for decrease and increase that may not be identical to what is already being measured by the PBSP as target behaviors.

Summary: San Antonio SSLC made progress in that, for most individuals, psychiatric indicators for decrease were identified in one or more documents and the indicators were consistently identified. There was a need for the indicators to be defined in observable terminology. The next steps would be including the goals in the IHCP section of the ISP and ensuring reliable and consistent data collection regarding the indicators. Regarding indicators for increase or positive/desirable behaviors that indicate the individual’s condition (or ability to manage the condition) is improving; there is a need for development of these indicators to ensure that the indicators are consistent with the individual’s diagnoses and reflect an improvement in symptom experience.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: Some items were missing from many of the CPEs. This may be, at least in part, a function of the CPEs being a few years old and, therefore, requiring some updating to meet criteria. Psychiatry completed CPEs as required for new admissions, but some other admission-related documentation was not found. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
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.	22%	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1

		2/9									
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	50% 2/4		1/1				0/1		0/1	1/1
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	67% 6/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
<p>Comments:</p> <p>14. The Monitoring Team looks for 14 components in the CPE. Two of the CPEs included the required components, Individual #118 and Individual #375. The remaining evaluations were missing one to two elements. Four evaluations were missing one element and three evaluations were missing two elements. The most common deficient element was the information regarding the bio-psycho-social formulation. This was in need of improvement in five examples.</p> <p>15. For the four individuals admitted in the two years prior to the onsite review, all had a CPE performed within 30 days of admission. Individual #357 and Individual #375 did not also have an IPN documented by primary care within the first business day after admission.</p> <p>16. There were three individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #385, Individual #139, and Individual #362.</p>											

Outcome 5 – Individuals’ status and treatment are reviewed annually.											
Summary: Annual reviews were completed and submitted for most, but not all, individuals. Indicator 17 improved to its highest scoring since monitoring began. Annual report content needed some additions to meet criteria and psychiatrists needed to attend annual meetings (or there needed to be a rationale as to why not). These indicators will remain in active monitoring.											
Even so, many managers and staff around campus reported the regular availability and responsiveness of the psychiatrists when requested or needed by teams.			Individuals:								
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
17	Status and treatment document was updated within past 12 months.	71% 5/7	1/1	N/A	1/1	0/1	0/1	1/1	1/1	1/1	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	N/A	0/1	0/1	0/1	0/1	0/1	0/1	N/A
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	22% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

17. Seven individuals required annual evaluations. Five were completed.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. None of the annual evaluations contained all of the required elements. The evaluations were missing from three to seven elements. There was a need for improvement overall with regard to the review of the combined behavioral health review/formulation and the risk versus benefit discussion regarding psychotropic medications.

19. Six individuals requiring an annual CPE had one completed prior to the annual ISP meeting. Individual #139 required an annual CPE, but this was not completed. There was, however, documentation of a quarterly clinic completed within 90 days prior to the ISP meeting.

20. The psychiatrist attended the ISP meeting for two of the individuals in the review group. If the psychiatrist does not participate in the ISP meeting, there needs to be some documentation that the psychiatrist participated in the decision to not be required to attend the ISP meeting; this can be by the psychiatrist attending the ISP preparation meeting, or by some other documentation/note that occurs prior to the annual ISP meeting. Even so, in the three-month period between the ISP preparation meeting and the annual ISP meeting, the status of the individual may have changed, as there may have been psychiatry related incidents, a change in medications, and so forth. The presence of the psychiatrist always allows for richer discussion during the ISP with regard to the required elements.

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

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
Summary: PSP content met criteria. This indicator will remain in active monitoring.											
Individuals:											
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

(PSP) is appropriate for the individual, required documentation is provided.	2/2										
Comments: 22. PSP documents regarding Individual #129 and Individual #178 were reviewed. The PSPs were detailed and contained a large amount of information. Both examples included the required elements with a detailed purpose and description of the psychiatric symptoms for monitoring.											

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: Current, signed consent forms existed for each medication. This was the case at San Antonio SSLC for the last three reviews too (with one exception in each review). Therefore, indicator 28 will be moved to the category of requiring less oversight. For the remaining content requirements (indicators 30 and 31), the psychiatrists made changes in June 2018 such that criteria were met since then. This was reflected in newer documents and should result in high performance scores for both indicators at the next review. They will remain in active monitoring.					Individuals:						
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	Due to the Center’s sustained performance, this indicator was moved to the category of requiring less oversight.									
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.	Due to the Center’s sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 28. Current medication consent forms were provided for all medications prescribed for the individuals included in the review group. 30. The risk versus benefit discussion was not included in the consent forms in the nine examples. There was information regarding the medication side effects and the risk to the individual with regard to increased symptoms if the medication was not utilized, but the forms did not include a comprehensive risk/benefit discussion. Discussions with the facility psychiatric clinic staff revealed that, as of June 2018, they had revised their consent form documentation process in order to address the risk/benefit discussion. Examples were reviewed for an additional five individuals (who were not in the review group), and these included the required documentation. This was good to see.											

31. The consent forms for the individuals in the review group did not include alternate, individualized, non-pharmacological interventions. Discussions with the facility psychiatric clinic staff revealed that as of June 2018, they had revised their consent form documentation process in order to address the need for individualized alternate and non-pharmacological interventions. Examples were reviewed for an additional five individuals (who were not in the review group), and these included the required documentation. This was good to see.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: In response to problems identified at the last review, the director of behavioral health services and her staff took actions to improve their data systems to PBSP target and replacement behaviors, and to ensure that data were reliable. As a result, performance on indicator 5 improved to 75% from 0% at the last two reviews. Indicator 5 will remain in active monitoring.					Individuals:						
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
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.	75% 6/8	1/1	1/1		1/1	0/1	1/1	0/1	1/1	1/1
<p>Comments:</p> <p>5. All individuals had interobserver agreement (IOA) and data collection timeliness (DCT) data that indicated that the data were reliable.</p> <p>Individual #380 and Individual #139’s progress notes, however, indicated that their behavioral specialists observed several incidents of PBSP data being incorrectly recorded, therefore, their data were scored as not reliable.</p> <p>In response, the behavior health specialists took action to improve the reliability of PBSP data. It was good to see this level of self-identification of this problem.</p>											

Overall, there was a substantial improvement in the reliability of the PBSP data from the last review when none of the data (0%) were judged to be reliable.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
Summary:					Individuals:						
#	Indicator	Overall Score									
10	The individual has a current, and complete annual behavioral health update.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
11	The functional assessment is current (within the past 12 months).										
12	The functional assessment is complete.										
Comments:											

Outcome 4 - All individuals have PBSPs that are current, complete, and implemented.														
Summary:					Individuals:									
#	Indicator	Overall Score												
Criteria were met for indicator 15 for all but one individual. However, given the serious and complex nature of this individual's behavioral and psychiatric presentation, this indicator will remain in active monitoring. However, with sustained high performance, especially for individuals with complex needs, such as this individual, this indicator might be moved to the category of requiring less oversight after the next review.														
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.	362	134	129	118	139	357	380	375	385			
14	The PBSP was current (within the past 12 months).													
15	The PBSP was complete, meeting all requirements for content and quality.	83% 5/6		1/1		1/1	1/1	0/1	1/1		1/1			
Comments: 15. Individual #357's current PBSP referenced a CIP and contingent helmet procedure that was not in her plan at the time of PBSP. Additionally, her PBSP did not have reinforcement clearly specified, and her replacement behavior was not functional and the PBSP did not include a rationale for why it was not functional.														

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 this review and the past two reviews, PCPs generally completed timely annual medical assessments for individuals reviewed (Round 12 – 88%, Round 13 – 88%, and Round 14 - 88%), Indicator b will move to the category requiring less oversight. Although some progress was noted, the Center should continue to focus on the timeliness of interim medical reviews. Indicator c will remain in active oversight.				Individuals:							
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	88% 7/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	0/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	63% 5/8	1/1	N/A	1/1	0/1	1/1	0/1	0/1	1/1	1/1
Comments: b. and c. None.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the medical assessments, with particular focus on, as applicable, family history, childhood illnesses, and plans of care for each active medical problem. More work was needed, but some improvement was noted with regard to PCPs completing quality interval medical reviews. Indicators a and c will remain in active oversight.				Individuals:							
#	Indicator	Overall	357	134	347	247	331	352	36	370	178

		Score									
a.	Individual receives quality AMA.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	50% 8/16	0/2	N/A	2/2	2/2	0/2	1/2	0/2	1/2	2/2
<p>Comments: a. It was positive that Individual #352's AMA included all of the necessary components, and addressed the individual's medical needs with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, social/smoking histories, 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 complete physical exams with vital signs. Most, but not all included pertinent laboratory information, and updated active problem lists. 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.</p> <p>c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #357 – seizures/neurology, and osteoporosis; Individual #134 – diabetes, and constipation/bowel obstruction; Individual #347 – seizures, and other: elevated alkaline phosphatase; Individual #247 – cardiac: hyperlipidemia, and other: benign prostatic hyperplasia (BPH); Individual #331 – cardiac disease: hypertension, and gastrointestinal (GI) problems; Individual #352 – constipation/bowel obstruction, and other: anemia; Individual #36 – osteoporosis, and diabetes; Individual #370 – respiratory compromise, and cardiac disease; and Individual #178 – other: chronic kidney disease, and infections: latent tuberculosis infection (LTBI)].</p> <p>More work was needed, but some improvement was noted with regard to PCPs completing quality interval medical reviews. For those that did not score positively, some of the problems included: no discussion of the active medical problem, incomplete updates/data and discussion of information relevant to the active medical problems, and/or lack of discussion of relevant consultations and their impact on the individual's care/treatment.</p>											

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: As indicated in the last several reports, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
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	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	considerations.											
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	41% 7/17	1/2	1/2	1/2	1/2	0/1	0/2	1/2	2/2	0/2	
<p>Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #357 – seizures/neurology, and osteoporosis; Individual #134 – diabetes, and constipation/bowel obstruction; Individual #347 – seizures, and other: elevated alkaline phosphatase; Individual #247 – cardiac: hyperlipidemia, and other: benign prostatic hyperplasia (BPH); Individual #331 – cardiac disease: hypertension, and GI problems; Individual #352 – constipation/bowel obstruction, and other: anemia; Individual #36 – osteoporosis, and diabetes; Individual #370 – respiratory compromise, and cardiac disease; and Individual #178 – other: chronic kidney disease, and infections: LTBI).</p> <p>None of the IHCPs reviewed included action steps to sufficiently address the chronic or at-risk conditions in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.</p> <p>b. Some improvement was noted with regard to ISPs/IHCPs defining the frequency of interval medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. The following individuals' ISPs/IHCPs defined the frequency: Individual #357 – seizures/neurology; Individual #134 – constipation/bowel obstruction; Individual #347 – seizures; Individual #247 – cardiac: hyperlipidemia; Individual #36 – osteoporosis; and Individual #370 – respiratory compromise, and cardiac disease. For the following risk, the IDT defined the frequency as six months, but given the severity of the individual's level of risk, this frequency was not sufficient to meet his needs: Individual #36 – diabetes.</p>												

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.												
Summary: The timely completion of annual dental exams to coincide with individuals' ISP meetings has not improved despite past reports identifying this problem. The Center should also continue its focus on improving the quality of dental exams and summaries. The remaining indicators will continue in active oversight.					Individuals:							
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178	
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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.										
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the	13% 1/8	0/1	N/A	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1

	ISP meeting.										
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	Individual receives a comprehensive dental examination.	22% 2/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	22% 2/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1

Comments: a. For seven of eight individuals reviewed (i.e., the ninth individual was newly-admitted), the dental exams on which the annual dental summaries were based 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. This has been a repetitive finding, which the Center has not addressed.

b. It was positive that for two of the nine individuals reviewed, the dental exams included all of the required components. It was also good to see that all of the remaining dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- Periodontal risk;
- Sedation use;
- A summary of the number of teeth present/missing;
- Treatment provided/completed; and
- An odontogram.

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

- An oral cancer screening;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- A treatment plan: a number of individuals had advanced periodontal disease, but the treatment plans documented did not sufficiently address their needs; and
- Periodontal charting.

c. It was good to see that all of the dental summaries reviewed included the following:

- Effectiveness of pre-treatment sedation;
- Recommendation of need for desensitization or another plan;
- A description of the treatment provided (i.e., treatment completed);
- The number of teeth present/missing;
- Dental care recommendations;
- Provision of written oral hygiene instructions; and

- Recommendations for the risk level for the IRRF.
- Moving forward, the Center should focus on ensuring dental summaries include, as applicable:
- Treatment plan, including the recall frequency; and
 - Dental conditions that could cause systemic health issues or are caused by systemic health issues.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: For all nine individuals reviewed, nurses completed timely annual or new-admission nursing reviews and physical assessments. Some problems were noted with regard to nurses’ timely completion of quarterly nursing record reviews and/or physical assessments. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
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.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual’s annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	67% 6/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1
<p>Comments: a.i. and a.ii. It was positive that for all nine individuals reviewed, nurses completed timely annual comprehensive nursing reviews and physical assessments.</p> <p>a.iii. With regard to quarterly nursing record reviews and physical assessments, problems included:</p> <ul style="list-style-type: none"> • For Individual #347, a quarterly nursing review was due by 7/31/18, but the Center did not submit any documentation to show the RN Case Manager (RNCM) completed a review. • For Individual #331, a quarterly nursing review was due by 8/31/18. However, based on the documentation the Center submitted, it was not until 10/1/18 that the RNCM completed a review. • For Individual #370, a quarterly nursing review was due by 4/30/18. However, based on the documentation the Center submitted, it was not until 5/10/18 that the RNCM completed a review. 											

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: Nurses need to work on improving the quality of annual and quarterly physical assessments to ensure they address the necessary components. Work also is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. For some of the individuals reviewed who experienced changes of status, nurses completed assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	Individual receives a quality annual nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	33% 3/9	0/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual receives a quality quarterly nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	67% 2/3	N/A	0/1	N/A	N/A	N/A	N/A	N/A	1/1	1/1

Comments: a. It was positive that all of the annual or new-admission nursing record reviews included the following:

- Social/smoking/drug/alcohol history;
- Immunizations;
- Consultation summary; and
- Tertiary care.

Most, but not all included:

- Active problem and diagnoses list updated at time of annual nursing assessment (ANA); and
- List of medications with dosages at the time of the ANA.

The components on which Center staff should focus include:

- Family history: at times, no family history was provided, or the information included was inconsistent with other documentation, such as the AMA;
- Procedure history: for some individuals, major procedures were omitted;
- Lab and diagnostic testing requiring review and/or intervention: for a number of individuals, concerning lab values were noted without comments describing PCP notification or review; and
- Allergies or severe side effects to medication: none of the assessments addressed allergies or severe side effects, and based on other documents provided, most individuals reviewed had one or more. The State Office Discipline Lead was working on fixing this issue within the electronic health record.

b. A number of the annual physical assessments did not include a Braden scale score, or a fall risk score. In addition, for many individuals, nurses did not document reassessment of abnormal or refused vital signs.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #357 – constipation/bowel obstruction, and seizures; Individual #134 – choking, and weight; Individual #347 – circulatory, and osteoporosis; Individual #247 – respiratory compromise, and constipation/bowel obstruction; Individual #331 – aspiration, and GI problems; Individual #352 – infections, and constipation/bowel obstruction; Individual #36 – respiratory compromise, and GI problems; Individual #370 – falls, and cardiac disease; and Individual #178 – dental, and skin integrity).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. For only one of the 18 risk areas reviewed, the nurse included status updates in annual assessment, including relevant clinical data (i.e., Individual #134 - weight). Nurses had not analyzed the information that was included, including comparisons with the previous quarter or year, and/or made 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.

d. Most, but not all of the quarterly nursing record reviews included:

- Active problem and diagnoses list updated at time of the quarterly assessment;
- Social/smoking/drug/alcohol history;
- List of medications with dosages at time of quarterly nursing assessment;
- Immunizations;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

The components on which Center staff should focus include:

- Family history: at times, no family history was provided, or the information included was inconsistent with other documentation, such as the AMA;
- Procedure history: for some individuals, major procedures were omitted; and
- Allergies or severe side effects to medication: None of the assessments addressed allergies or severe side effects, and based on other documents provided, most individuals reviewed had one or more.

e. For many individuals, nurses did not document reassessment of abnormal or refused vital signs. In some cases, vital signs were missing. At times, physical assessments did not include a Braden scale score, or a fall risk score. At times, nurses noted that individuals were "oriented x4," but provided no information about to what the individual was oriented.

g. The following provide findings related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- Individual #134's weight IHCP included a goal for her to lose weight. A Nutrition Comprehensive Assessment, dated 3/27/18, stated: "collaborative monitoring with RNCM who will monitor weights and notify dietitian and PCP of weight changes of > 5lbs in one month or more than a 5% change in weight over 1 month, >7.5% change in 3 months, or >10% change in 6 months." Based on documentation submitted, in April 2018, her weight decreased by more than five pounds in one month (i.e., on 3/13/18, she weighed 193 pounds, and on 4/16/18, she weighed 181.4 pounds, which represented a loss of 11.6 pounds); and between April and May 2018, she lost 13 pounds (i.e., a decrease from 181.4 pounds to 168.4 on 5/7/18). The documentation submitted included no nursing assessment related to this weight loss.
- On 6/4/18, Individual #370 went to the ED related to a fall, with a head injury, and laceration that required four staples. It was positive that at 6:28 a.m., nursing staff documented a physical assessment in IView that included vital signs and a neurological assessment. At 6:50 a.m., a nursing IPN recorded the time of physician notification of the fall with injury. A nursing IPN, dated 6/4/18, at 9:17 a.m., showed the nurse followed standards of care/guidelines based on the individual's injury, and signs and symptoms.
- On 4/17/18, Individual #178's right thumb was amputated when another individual bit him. On 4/17/18, at 1:27 p.m., a nursing IPN documented the injury to the individual's right thumb, noting the nurse was notified at 11:41 a.m., and arrived at 11:43 a.m., at which time the nurse applied a pressure dressing and notified the physician. The nurse followed applicable standards of care for the type of injury described and the individual's signs and symptoms, including assessment of vital signs

and a pain assessment, as well as physician notification. The individual was transferred to the hospital, where he was admitted. The physical exam showed amputation of the distal phalanx.

Outcome 5 – Individuals’ ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

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

Individuals:

#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
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. Substantial work was needed to improve the nursing interventions included in individuals’ IHCPs.

Physical and Nutritional Management

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

Summary: Improvement is still needed with regard to timely referral of individuals to the PNMT. Generally, once individuals were referred, the PNMT completed timely reviews, and completed comprehensive assessments, when needed. It was good to see that for one individual, the PNMT conducted a quality comprehensive

Individuals:

assessment. Unfortunately, the other PNMT assessment reviewed was of poor quality. These indicators will continue in active oversight.											
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	60% 3/5	0/1	N/A	0/1	N/A	N/A	N/A	2/2	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	80% 4/5	0/1		1/1	N/A			2/2	1/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	50% 1/2	N/A		1/1	N/A			N/A	0/1	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	80% 4/5	0/1		1/1	N/A			2/2	1/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	0% 0/1	N/A		N/A	N/A			N/A	0/1	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	40% 2/5	0/1		1/1	N/A			0/2	1/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: <ul style="list-style-type: none"> Presenting problem; Pertinent diagnoses and medical history; Applicable risk ratings; Current health and physical status; Potential impact on and relevance to PNM needs; and Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan. 	0% 0/4	0/1		0/1	N/A			0/2	N/A	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	50% 1/2	N/A		1/1	N/A			N/A	0/1	
Comments: a. through d., e., and g. For the five individuals that should have been referred to and/or reviewed by the PNMT: <ul style="list-style-type: none"> When she met criteria, Individual #357's IDT did not refer her to the PNMT. Although the data related to falls varied considerably across sources, it appeared the individual met criteria in December 2017 (i.e., she fell five times in November, and five times in December). Again, between June 2018 and September, she fell numerous times (i.e., she fell four times in May, three times in June, four times in July, three times in August, and four times in September). Although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined at a <u>minimum</u> according to the following qualifying event/threshold..." (emphasis added). IDTs still need to refer or the PNMT 											

needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. This individual's continuing falls placed her at significant risk of harm, and, at a minimum, the PNMT should have conducted a review.

- Individual #347 met referral criteria as early as December 2017, with a 10% weight loss in less than six months (i.e., since July, when she weighed 122.4 pounds). In December 2017, when she weighed 109.8 pounds, the PNMT did not conduct a review, but did discuss the individual's weight. However, their calculation of weight loss only took into consideration the previous three months, as opposed to six months, so they did not catch the 10% weight loss. On 3/1/18, the PNMT conducted a review for a decline in physical and swallowing status. They followed her for several months, and then, on 6/7/18, held a discussion related to weight loss.

Her weight loss continued on through 6/25/18, at which time the IDT made a referral. At the time of the referral, she weighed 102.1 pounds, and her estimated desired weight range (EDWR) was 108 to 132 pounds. On 7/16/18, the PNMT completed an assessment, the quality of which is discussed below.

- On 5/3/17, the PNMT conducted an assessment of Individual #247's respiratory compromise. Although he remained on their caseload, the Monitoring Team did not score the review, assessment, etc., because the PNMT completed them over a year ago.
- With regard to Individual #36's two femur fractures, the PNMT conducted a review on 3/15/18. The fractures were an incidental finding during a computed tomography (CT) scan on 3/12/18 of the pelvis due to cellulitis of his scrotum. The PNMT chose not to complete a comprehensive assessment, but rather conducted a review. Consultations were pending, and interventions and supports evolved over subsequent weeks. There was suspicion that fractures occurred when he was transferred to CT table as a lift was not used for that transfer per staff. The PNMT indicated that there would be follow up on 4/12/18, to review further updates from orthopedics (i.e., they actually met on him again on 3/29/18 and on 4/12/18, at which time they decided to continue oversight with follow up on 6/21/18 after the next orthopedic consult. At that time, they stated that fractures continued to heal and skin issues had improved, so they discharged him from their oversight at that time. In the original review, they did recommend that direct support professionals should always ensure that he only be transferred via mechanical lift for future appointments, or as alternative a wheelchair with a drop side and draw sheet transfer. They revised the PNMP for care instructions per Ortho recommendations and fractures were healing. However, the PNMT made no recommendations for IHCP interventions and/or measurable outcomes.

With regard to his emesis, the PNMT met on 7/12/18, after 19 episodes of emesis between 5/6/18 and 7/11/18. The review was documented on 7/16/18. There was some discrepancy in their analysis of the occurrences. The PNMT again chose not to complete a comprehensive assessment, but completed a review. The individual was hospitalized at the time for removal of his right testicle. Again, the PNMT made no recommendations for IHCP interventions and/or measurable outcomes.

- Beginning in July 2017, Individual #370 had numerous falls: July 2017 - 7 (including three in one day, with a PNMT review at that time); August 2017 - 2; September 2017 - 7; October 2017 - 12; November 2017 - 5; December 2017 - 3; January 2018 - 3; February 2018 - 1; March - 2018 - 0; April 2018 - 1; May 2018 - 1; June 2018 - 8; July 2018 - 1; and August 2018 - 1. On 10/12/17, the IDT made a referral to the PNMT. On 11/14/17, the PNMT completed its assessment.

As discussed in the medical section, on 4/27/18, the PCP documented that Individual #370 fell and hit her head. Due to the increased risk for intracranial bleeding secondary to Aspirin use, the PCP referred her to the ED for evaluation. On 4/28/18, another PCP evaluated the individual and documented that per nursing documentation the CT of the head was negative. The

physical exam was pertinent for facial ecchymosis.

In June 2018, she sustained a laceration to the back of her head, requiring four staples. The IDT documented she was not wearing slip socks. From 6/14/18 to 6/18/18, she was hospitalized for bronchitis and evaluation of her falls, including a STAT MRI of her spine due to the frequent falls.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it was difficult to determine which members of the PNMT participated in the PNMT assessments. In some cases, PNMT members reviewed and approved the document once it was finalized, which sufficed as a “signature.”

h. The following summarizes the findings related to the two assessments that the PNMT completed:

- The PNMT assessment for Individual #347 met criteria. The PNMT recalculated her EDWR and decreased it from 108 to 132 pounds to 87 to 107 pounds, because they re-measured her height and determined she was 59 inches tall, rather than 64 inches. The PNMT suspected the etiology of her weight loss was chemical hepatitis secondary to Lipitor. Despite caloric increases, her weight did not increase in the time frame expected. They determined that she required continued caloric increases. The interventions agreed upon were to increase her caloric intake, monitor to ensure consistent provision of snacks, and monitor her intake with an expectation that she would consume 75% to 100% of her meals, 75% of the time by 1/31/19. To measure the success of the interventions, they identified a clinical indicator of maintaining a weight of 97 pounds for three months.
- The PNMT assessment for Individual #370 was a series of notes and questions, as opposed to an analysis. The PNMT, working in conjunction with the IDT, did not identify the underlying cause(s) or etiology(ies) of her numerous falls.

Outcome 3 – Individuals’ ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.												
Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals’ PNM needs. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. In addition, many action steps were not measurable. With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals’ PNMPs. These indicators will continue in active oversight.			Individuals:									
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178	
a.	The individual has an ISP/IHCP that sufficiently addresses the individual’s identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	

b.	The individual's plan includes preventative interventions to minimize the condition of risk.	22% 4/18	0/2	2/2	1/2	0/2	0/2	0/2	0/2	1/2	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.	33% 3/9	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	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% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #357 - choking, and falls; Individual #134 - falls, and choking; Individual #347 - fractures, and weight; Individual #247 - skin integrity, and respiratory compromise; Individual #331 - fractures, and GI problems; Individual #352 - skin integrity, and falls; Individual #36 - fractures, and GI problems; Individual #370 - choking, and falls; and Individual #178 - choking, and falls.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks. Those that included preventative interventions were for: Individual #134 - falls, and choking; Individual #347 - weight; and Individual #370 - falls.

In its comments on the draft report, the State disputed the finding for Individual #134, and stated: "The IHCP includes the [sic] both the PNMP supports for falls (PRN gait belt and shower bench)... TX-SA-1810-II.3..., page 10 (page 11 when including coversheet)." The Lead Monitor reviewed the document the State referenced, and did not modify the finding. The supports read: "H [Habilitation Therapies]- Follow PNMP for shower bench," and "H- Follow PNMP for prn gaitbelt." Habilitation Therapies staff are not the only staff who need to follow PNMP supports, so these supports also should have included at a minimum direct support professional staff in residential and day programs. Moreover, as has been discussed with Center staff and State Office staff, IHCPs need to include specific, and measurable supports. In other words, the IHCP should define the specific support that the PNMP needs to include, and the PNMP should reflect the supports on which the IDT agrees. For example, based on review of the current PNMP for Individual #134, the gait belt support should have read: "When visibly unsteady/lethargic/sleepy, staff to provide hands-on (firmly grasping) gait belt assistance."

c. All individuals reviewed had PNMPs and/or Dining Plans. Problems varied across the PNMPs and/or Dining Plans reviewed.

- It was positive that all of the PNMPs were reviewed and/or updated within the last 12 months. In addition, as applicable to the individuals' needs, all included:
 - Descriptions of assistive/adaptive equipment;

- Mobility instructions;
- Bathing instructions;
- Toileting/personal care instructions;
- Handling precautions or moving instructions; and
- Medication administration instructions.
- As applicable to the individuals, most, but not all of the PNMPs reviewed:
 - Specified risk levels and triggers;
 - Included necessary photographs;
 - Provided complete positioning instructions;
 - Provided complete and consistent transfer instructions;
 - Provided complete mealtime instructions;
 - Provided correct oral hygiene instructions; and
 - Provided complete communication strategies.

With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs.

e. The IHCP that identified the necessary clinical indicators was for: Individual #347 – weight.

f. The IHCP that identified triggers and actions to take when they occur was for Individual #370 – falls.

g. Often, the IHCPs reviewed did not include action steps for PNMP monitoring, or they did not define the frequency of PNMP monitoring. Those that did were for Individual #357 – choking, and Individual #178 – choking.

In its comments on the draft report, the State disputed this finding for Individual #134, and stated: “The IHCP includes... the frequency of monitoring in document TX-SA-1810-II.3..., page 10 (page 11 when including coversheet). The supports and frequency of monitoring can also be found in the ISP Document, TX-SA-1810-II.1.a-b..., at the bottom of page 16 of the document, (page 17 when including coversheet).” The Lead Monitor reviewed the documents the State referenced, and did not modify the finding. The IHCP did not include an intervention for monitoring. In the “Reason” section for the intervention related to Habilitation Therapy staff using the gait belt with the individual, monitoring was mentioned, but it was not listed as a measurable intervention. (The State’s comments did not make this distinction.) In addition, the Lead Monitor has confirmed twice with State Office staff that the IHCP (Document #3) is where the Monitoring Team members will look for IHCP interventions. It appeared from the narrative section of the ISP that it was the IDT’s intent to include monitoring as an intervention, but the IHCP did not reflect that decision. The QIDP integrated reviews should include all IHCP interventions, and if IHCPs do not include all agreed-upon interventions, then tracking of important functions such as PNMP monitoring will not occur.

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	357	134	347	247	331	352	36	370	178
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.	67% 2/3	N/A	N/A	N/A	0/1	1/1	N/A	1/1	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.	100% 1/1				1/1	N/A		N/A		
<p>Comments: a. and b. As of August 2018, Individual #247 had returned to oral intake with the tube used as needed if he refused oral intake and for medications. At the time of his ISP meeting in September 2018, it appeared he received everything by mouth. The PNMT developed a plan, but the Center did not submit data showing implementation of the plan.</p> <p>More specifically, following an MBSS on 1/10/18, the PNMT had outlined a clear plan to resume oral intake in their note on 1/11/18, with an ISPA meeting held on 1/29/18. The SLP conducted trials that were documented in the ISPA, and staff were to implement oral intake per the PNMP with the SLP monitoring and determining progression as goals were met. It could not be determined if this was documented in the IHCP or QIDP monthly summaries, as this was prior to 4/1/18, which was the beginning date for the document request. Then, he became ill and this plan was suspended until April 2018, when it resumed, per an ISPA, held on 4/16/18 (though documentation indicated that trials with the SLP had begun on 3/1/18 in order to develop the plan). Documentation was inconsistent for this and for follow-up after that as well. Clear documentation, including data related to his status and progress was not provided. A note also was not found from the SLP stating that he had met all of the established goals and was deemed safe to continue, or that he had met all the criteria laid out in the plan.</p>											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.	
Summary: As indicated in the last report, a significant issue was that Center staff had not followed the current guidelines for considering when an OT/PT comprehensive assessment 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 provided sufficient clinical justification for why an update met the individual’s needs. The assessments reviewed needed considerable	Individuals:

improvement. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	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.	25% 2/8	1/1	N/A	0/1	0/1	1/1	0/1	0/1	0/1	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
c.	Individual receives quality screening, including the following: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ▪ 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% 0/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/2	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
<p>Comments: a. and b., and d. The following concerns were noted:</p> <ul style="list-style-type: none"> For Individual #357, the OT/PT completed a timely update for her most recent ISP meeting. However, no evidence was found that the PT participated in the comprehensive assessment on which the update was based. For Individual #134, there was no evidence that the OT participated in the assessment process. <p>In its comments on the draft report, the State disputed this finding, and stated: "Individual #134 received an OT-PT comprehensive assessment on 4/5/18 and this assessment comprises Document TX-SA-1810-II.89..." The State's comment did not directly address the concern the Monitoring Team expressed in the draft report. However, in a second comment related to the same issue, the State also disputed the finding for Individual #357, and indicated: "Due to only being able to see parts of the assessment at once in IRIS, our current process is that assessments are written together by both the OT and PT in Microsoft Word format. Each discipline completes some sections alone and (for example, PT will complete feet, mobility, gait analysis and ROM for LE) and some sections are completed as a team. Upon completion, one of the therapists, either the OT or PT, then cut and paste the entire completed assessment into the IRIS assessment forms. The evidence of participation by both OT and PT is seen under the 'Team Members' section of the assessment, where both therapists' names are included." Given that OTs and PTs are licensed clinicians, a mechanism needs to be in place to verify the participation of each therapist in the process. Given the ongoing challenges with IRIS, the State should propose a mechanism to allow this verification (i.e., simply including the names of "team members" at the bottom of the report does not suffice).</p> <ul style="list-style-type: none"> As was a problem at the time of the last review, the following individuals' last comprehensive OT/PT assessments were completed at least three years ago: Individual #347, Individual #247, Individual #352, Individual #36, Individual #370, and Individual #178. 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. <p>In six comments to the draft report, the State disputed these findings. The State's comments referenced excerpts from the assessments that the Monitoring Team reviewed as part of its initial review. The State contended that these general statements about individuals' statuses sufficed as clinical justification for the lack of completion of comprehensive assessments at the three-year mark. As was discussed in the draft report (and is included below) numerous issues existed with regard to the quality of the updates that OTs and PTs completed. Given that the assessments did not meet criteria with the following sub-indicators, the assessors had not documented sufficient clinical justification to conclude (i.e., they did not have the data to support) that individuals' statuses had not changed:</p> <ul style="list-style-type: none"> 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 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 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 Monitor did not make any changes to these findings.

- Although this did not impact the scoring for these indicators, the Monitoring Team identified a significant issue for Individual #311. After his left intertrochanteric hip fracture in May 2016, on 6/27/16, he was discharged after a 30-day hospitalization. On 8/11/16, the OT/PT completed a comprehensive assessment with no recommendations for direct therapy once his health status improved. The 2017 update did not address whether or not intervention was provided, but it appeared that none was provided and no rationale was offered.

e. Overall, the OT/PT assessments needed considerable work. However, it was positive that the eight updates reviewed (i.e., to provide feedback on the updates, the Monitoring Team reviewed all eight that the Center submitted) met criteria, as applicable, with regard to:

- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).

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

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; and
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings.

The Center should focus most on the following sub-indicators:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of 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;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Summary: Although some progress was noted with regard to descriptions in ISPs of Individuals:

individuals' OT/PT functional statuses, and IDTs' reviews and updates to PNMPs, improvement is needed with regard to all of these indicators. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.												
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178	
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	44% 4/9	0/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1	
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	44% 4/9	0/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	N/A	N/A	N/A	0/1	
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	N/A										
<p>Comments: a. Some improvement was noted with regard to ISPs including concise, but thorough descriptions of individuals' OT/PT functional statuses. Therapists should work with QIDPs to continue to make improvements.</p> <p>b. Some improvement was noted with regard to ISPs providing evidence of what the IDT reviewed, revised, and/or approved with regard to PNMPs and/or positioning schedules. Again, therapists should work with QIDPs to continue to make improvements.</p> <p>c. Examples of concerns included:</p> <ul style="list-style-type: none"> For Individual #357, the OT/PT indicated that her fall risk was not related to gait abnormalities or balance deficits, but rather behavioral and aggression concerns, or possibly medications. They concluded that direct therapy was not indicated. They listed and described 22 falls occurring between 5/1/17, and 3/16/18. However, 18 of these reported falls did not have an associated behavioral component identified in the description, which called into question the assessment findings. This is an example in which it appeared therapists concluded that the individuals' falls were behaviorally-related without looking further at the potential role for an OT/PT. Even if an individual is experiencing falls while running after staff or another individual, or kicking, etc., it might be necessary to determine whether or not the individual has sufficient skills to run, kick a ball, etc., as these are skills that most adults are able to do without falling. Often, therapists focus on ambulation, as opposed to the individual's ability to navigate steps, stairs, curbs, stand on one foot, run, kick a ball, and other common gross motor skills. <p>In addition, data related to the frequency of falls were not consistent between the OT/PT assessment, episode tracker, and data</p>												

in document submitted on site. According to the data submitted on site, from April through September 2018, she fell 16 times, but the episode tracker identified 12 falls. For the period between September 2017 and March 2018, the OT/PT assessment identified 19 falls, but the episode tracker identified only nine.

The OT/PT recommended a peanut-shaped exercise ball, but provided no further direction, and no rationale for why the ball was indicated. In addition, the OT did not outline a specific sensory assessment to justify the need for a program and specific interventions. For example, the ISP stated she enjoyed the trampoline park and mini trampoline, but the OT and/or IDT did not connect these to sensory issues.

- According to documentation the Center submitted on site, between 4/1/18 and 10/15/18, Individual #134 fell nine times (although the episode tracker listed four falls during this time period). The OT/PT did not complete an assessment to determine whether or not ISP/IHCP modifications were needed.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.														
<p>Summary: As indicated in the last report, a significant issue was that Center staff had not followed the current guidelines related to when a communication comprehensive assessment should be repeated. For a number of individuals reviewed, the three-year mark had passed, and Speech Language Pathologists (SLPs) had not completed a new comprehensive assessment, or provided sufficient clinical justification for why an update met the individual’s needs. As also indicated in the last report, significant work is needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals’ functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals’ communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.</p>					Individuals:									
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178			
a.	Individual receives timely communication screening and/or assessment:													
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive	Due to the Center’s sustained performance, these indicators moved to the category requiring less oversight.												

	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.	14% 1/7	1/1	N/A	0/1	0/1	0/1	0/1	0/1	N/A	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	33% 3/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: <ul style="list-style-type: none"> • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: <ul style="list-style-type: none"> ▪ 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	N/A	1/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/6	N/A	N/A	0/1	0/1	0/1	0/1	0/1	N/A	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a., b. and d. As indicated in the last report, for a number of individuals reviewed, at least three years had passed since their last comprehensive communication assessment was completed, and per policy, the SLPs should have considered completing new comprehensive assessments, and if the decision was to complete an update, the SLPs needed to provide clear clinical justification. For the following assessments: Individual #347, Individual #247, Individual #331, Individual #352, Individual #36, and Individual #178, SLPs had not provided sufficient justification for not completing another comprehensive assessment. As a result, individuals did not have timely assessments and assessments that met their needs.											

In six comments to the draft report, the State disputed these findings. The State’s comments referenced excerpts from the assessments that the Monitoring Team reviewed as part of its initial review. The State contended that these general statements about individuals’ statuses sufficed as clinical justification for the lack of completion of comprehensive assessments at the three-year mark. As was discussed in the draft report (and is included below) numerous issues existed with regard to the quality of the updates that OTs and PTs completed. Given that the assessments did not meet criteria with the following sub-indicators, the assessors had not documented sufficient clinical justification to conclude (i.e., they did not have the data to support) that individuals’ statuses had not changed:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual’s current communication abilities/skills; and
- The effectiveness of current supports, including monitoring findings.

The Monitor did not make any changes to these findings.

c. Individual #370’s screening did not address health/medical history, medications, hearing, or vision.

e. Overall, the communications updates needed considerable work. Most, but not all of the seven updates reviewed (i.e., to provide feedback on the updates, the Monitoring Team reviewed all seven that the Center submitted) met criteria, as applicable, with regard to:

- The individual’s preferences and strengths are used in the development of communication supports and services; and
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

The Center should focus most on the following sub-indicators:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual’s current communication abilities/skills;
- The effectiveness of current supports, including monitoring findings; and
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

<p>Summary: Since the last review, some improvement was noted with regard to these indicators. To continue to move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals’</p>	<p>Individuals:</p>
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communication supports in ISPs. These indicators will continue in active oversight.											
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	56% 5/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	57% 5/7	1/1	N/A	1/1	0/1	1/1	0/1	1/1	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.	63% 5/8	1/2	N/A	0/1	1/1	1/1	0/1	1/1	N/A	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
<p>Comments: a. Although more work was needed, since the last review, more ISPs reviewed included complete functional descriptions of individuals' communication skills, and strategies for others to use when communicating with them.</p> <p>In its comments on the draft report, the State disputed the finding for Individual #134 (i.e., the State referenced Individual #347, but given the document citation, the Monitoring Team assumed the State actually meant Individual #134). The State indicated: "In Document TX-SA-1810-II.1.a-b... on page 2, the ISP states how this individual communicates (verbally), communication strategy (prompting her to face the speaker, and how staff should communicate with the individual (speak in a positive tone). Please change rating or explain in comments why this indicator was not scored 1/1." In explanation for the score of 0, Individual #134's ISP included limited information about how to communicate with her other than stating that she used English as her primary language and followed one- to two-step directions (i.e., using a positive tone would seem to be a basic tenant of communication with all individuals supported at the Center). It was unclear why the IDT said staff should prompt her to look at the speaker, rather than that staff should get her attention before giving instructions, asking questions, etc. The screening said she could answer yes/no and open ended questions, and that she spoke in complete sentences. The assessor mentioned that at times her volume was low, so the IDT could have suggested that staff ask her to repeat or speak louder, if they have difficulty understanding her. The assessor identified lethargy as an issue, so the IDT could have provided special instructions for communication if staff notice this. In addition, aggression was an issue for her, so a collaborative approach with the PBSP seemed warranted for her. Also, the communication section of her PNMP said "N/A."</p> <p>b. Similarly, since the last review, more ISPs reviewed documented what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.</p>											

d. It was positive that Individual #357's IDT held an ISPA meeting (i.e., on 10/2/18) to incorporate the direct therapy program for signing into her ISP.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.												
Summary: Again, about two-thirds of the SAPs were practical, functional, and meaningful and reliable data were collected for about two-thirds of the SAPs. With some of the upcoming changes in SAP management at San Antonio SSLC, these scores may improve even further. These two indicators will remain in active monitoring.					Individuals:							
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385	
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.											
4	SAPs are practical, functional, and meaningful.	56% 14/25	2/3	1/3	2/2	2/3	3/3	2/3	1/3	1/3	0/2	
5	Reliable and valid data are available that report/summarize the individual's status and progress.	68% 17/25	2/3	3/3	0/2	3/3	2/3	2/3	1/3	3/3	1/2	
<p>Comments:</p> <p>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 #129 and Individual #385 for a total of 25 SAPs for this review.</p> <p>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 #357's clothes washing SAP), or appeared to be compliance plans (e.g., Individual #385's drying his clothes SAP).</p> <p>5. It was very encouraging that the majority of SAPs had SAP integrity measures. This is an important part of a solid SAP system. Several integrity measures, however, did not include the IOA portion of the integrity measure (e.g., Individual #380's brush teeth SAP), or reliability data were below 80% and there was not documentation that staff were retrained, and those were, therefore, scored as 0.</p>												

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 increased performance compared with the					Individuals:							

last review. All three will remain in active monitoring.											
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
10	The individual has a current FSA, PSI, and vocational assessment.	78% 7/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	33% 3/9	0/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
<p>Comments:</p> <p>10. Individual #139 did not have a current PSI. Individual #118 did not have a PSI.</p> <p>11. Individual #357, Individual #129, and Individual #139's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.</p> <p>12. Individual #134's vocational assessment did not have recommendations for SAPs.</p>											

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, 22 of these indicators were in the category of requiring less oversight. For this review, 11 other indicators were added to this category, in restraints, psychiatry, behavioral health, and pharmacy.

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

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 health. In addition, integrated progress reports with data and analysis of the data generally 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.

In psychiatry, progress was seen for one individual (based upon there being an identified psychiatric indicator and reliable data).

Neuro-psychiatry clinics continued, which was good to see. Furthermore, the psychiatry department improved the documentation of these encounters.

In behavioral health, two individuals who had good reliable data were also making progress. If there was no progress, the Center identified actions to take for half of the individuals. When actions were identified, the Center implemented those actions.

For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. A number of individuals reviewed had deteriorating dental health or ongoing dental concerns. However, their IDTs had not set forth clinically relevant, achievable goals or corresponding reasonable plans to address their dental needs.

Acute Illnesses/Occurrences

With regard to acute illnesses/occurrences, in the months prior to the review, State Office provided training to all of the Centers on the development of acute nursing care plans. During this round of reviews, the Monitoring Team is working with State Office

on ensuring Centers provide the correct documentation for review of acute care plans. Given the timing of the San Antonio SSLC review, the Center was in the initial stages of implementing the revised acute care plan template/process. Center staff should continue to work with State Office to correct the issues with this critical nursing function.

Overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Center did not meet generally accepted standards of care, and for some individuals reviewed, significant concerns were noted. For at least the past five reviews, the Center has shown poor compliance with these requirements. For the acute issues reviewed that required ED transfers or hospitalizations, PCPs generally assessed and provided individuals with treatment prior to the transfers in accordance with accepted standards. However, they often did not conduct needed follow-up. As indicated in the last report, the Center needs to prioritize improvements in these areas.

In psychiatry, when individuals were showing psychiatric problems, they received IDT and psychiatry attention. Psychiatrist availability and follow-up was a strength of the San Antonio SSLC psychiatry program.

Implementation of Plans

Psychiatry clinics were observed for both psychiatrists. The clinics included appropriate staff members from the required disciplines. There was appropriate discussion. The psychiatrists did a good job of engaging with the individuals.

There was improvement in polypharmacy documentation. The format of the minutes/notes from each meeting was updated and there were more written justifications. The polypharmacy committee was still run by psychiatric clinical staff. Polypharmacy committee must be a facility-level review of the medication regimens.

Overall, the behavioral health services department addressed many of the deficits that were identified in the last review:

- Ensuring that all staff implementing PBSPs are trained.
- Improving the usefulness of PBSP graphs.
- Improving the PBSP data system.
- Improving measures of PBSP data reliability.

In behavioral health, areas that required attention included:

- Ensuring that actions are consistently documented in progress notes when individuals are not making expected progress.
- Ensuring and showing that behavioral measures of data reliability (IOA and DCT) and treatment integrity occur at established frequencies.

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 not provided to show that IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

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 PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate. Moreover, IHCPs did not include a full set of action steps to address individuals' medical needs. Although documentation generally was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs, until IHCPs include a full set of action steps related to medical interventions, this is not a true measure of the Medical Department's success (i.e., a false positive).

For the consultation reports reviewed, the PCPs generally indicated agreement or disagreement with recommendations, and did so in a timely manner. It was good to see improvement with regard to PCPs writing IPNs related to consultation reports. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

The individuals reviewed generally received needed dental x-rays, fluoride treatment, and restorative work. Areas needing continued efforts were the provision of prophylactic care, and tooth brushing instruction.

Since the last review, the Center improved its performance with regard to the inclusion of measurable action steps related to suction tooth brushing in applicable individuals' ISPs. In addition, for the three individuals reviewed that needed suction tooth brushing, staff had documented completion of it in accordance with the measurable action steps. However, all three individuals had either poor or fair oral hygiene, and their IDTs had not identified the frequency of monitoring of the technique and Dental Department staff were not completing monitoring. QIDPs also were not summarizing and analyzing data in the monthly integrated reviews.

Based on the individuals reviewed, the Clinical Pharmacist generally completed Quarterly Drug Regimen Reviews (QDRRs) timely. Improvement is needed with regard to the quality of the QDRRs, particularly with regard to recommendations related to concerning lab values, and the evaluation of individuals' risk for metabolic syndrome. The Center continued to make improvements with regard to practitioners' documentation of their decisions about agreement or disagreement with the Clinical Pharmacist's recommendations.

Proper fit of adaptive equipment was sometimes still an issue.

Since the last review, PNMP/Dining Plan implementation at San Antonio SSLC improved (i.e., Round 13 – 27%, and Round 14 – 53%). However, there were still numerous instances (47% of 53 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing

their physical and nutritional management risk. The Center, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
Summary: Criteria were met for all indicators. This has been the case for indicators 21 and 22 for the past two reviews, too. Indicator 26 is evaluated elsewhere in this report and has not been applicable since 2015. Therefore, these three indicators (21, 22, 26) will be moved to the category of requiring less oversight. That leaves indicator 20 as the sole indicator in this outcome that remains in active monitoring and, with sustained high performance, might also be moved to this category after the next review.					Individuals:						
#	Indicator	Overall Score	134								
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.	100% 1/1	1/1								
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,	100% 1/1	1/1								

	2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?										
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).										
26	The PBSP was complete.	N/A	N/A								
27	The crisis intervention plan was complete.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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 #134. Individual #134 had her fourth restraint in 30 days on 6/30/18. The ISPA to address those restraints was on 7/2/18.											

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: None of the individuals in the review groups who were not already receiving psychiatric services had a change of status warranting re-admission. Given the long-standing correct implementation of Reiss scales, the Monitor will move indicators 2 and 3 into the category of requiring less oversight, too.										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	N/A									

	services, the individual was referred to psychiatry, or a Reiss was conducted.										
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	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: For the psychiatric indicators for reduction, progress was seen for one individual. For psychiatric indicators for increase, the need for development of these indicators (see monitoring indicator 4) led to zero scores for those. When individuals were showing psychiatric problems, they received IDT and psychiatry attention. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/1	N/A	N/A	N/A	N/A	0/2	N/A	N/A	N/A	N/A
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	1/1	1/1	N/A	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
<p>Comments:</p> <p>8. There was an example of an individual who had goals for reduction included in the psychiatric documents and per the clinical documentation, was making progress with regard to their goals. Thus, one individual was scored 1 of 2 in the above scoring table.</p> <ul style="list-style-type: none"> For example, Individual #139 had notations that he had met goals regarding episodes of aggression and per psychiatric documentation, it was noted that he had been at his psychiatric baseline for a period of three months. Even so, he continued to require medication adjustments. The other individuals in the review group either did not have documented indicators or goals or were not meeting goals for reduction. <p>9. Individual #139 had met goals for reduction, but there were no updated goals documented.</p> <p>10-11. It was apparent that in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments) were developed and implemented.</p>											

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Psychiatry and behavioral health continued to work well together. They collaborated on various cases and, during the onsite week, created a plan to work together to identify (and define) psychiatric indicators for PBSPs. Numerous staff and managers around campus talked positively about the psychiatrists' presence, availability, and willingness to be active members of the IDT. Documentation improvement led to a 100% scoring for indicator 23 for the first time. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
23	Psychiatric documentation references the behavioral health target behaviors, <u>and</u> the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
<p>Comments:</p> <p>23. The psychiatric documentation briefly referenced the behavioral health target behaviors. The functional assessment discussed the role of the psychiatric disorder upon the presentation of the behaviors in all examples.</p> <p>24. The documentation did not reveal evidence of psychiatric participation in the development of the PBSP. Per discussions with the psychiatrists and behavioral health staff, the psychiatric providers were participating in the development of the psychiatric support plans (PSPs) and working to identify and define indicators for these plans. This was a good start that will, in the near future, also occur with PBSPs.</p>											

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: Neuro-psychiatry clinics continued, which was good to see. Furthermore, the psychiatry department improved the documentation of these encounters, resulting in 100% scores for all three indicators for the first time. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 3/3			1/1				1/1		1/1
26	Frequency was at least annual.	100%			1/1				1/1		

		2/2									
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 3/3			1/1				1/1		
<p>Comments: 25-27. These indicators applied to three of the individuals in the review group, Individual #385, Individual #380, and Individual #129. Individual #385 was a new admission to the facility, so he did not have had an annual review. This facility has a long running, very good, Neuro-Psychiatry clinic that is attended by the individual, the consulting neurologist, the primary care physician, and the treating psychiatrist.</p>											

Outcome 10 – Individuals’ psychiatric treatment is reviewed at quarterly clinics.											
<p>Summary: Psychiatric clinics were occurring as required, however, for two individuals, one of their quarterlies was one month late. Even so, given past performance, with a return to a higher score next time, this indicator (33) might be moved to the category of requiring less oversight after the next review. Some additions to the documentation should result in higher scores for indicator 34. Psychiatric clinics were well done and the Monitoring Team observed many of them for both psychiatrists. With sustained high performance, this indicator might also be moved to the category of requiring less oversight after the next review. All three indicators will remain in active monitoring.</p>					Individuals:						
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
33	Quarterly reviews were completed quarterly.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual’s psychiatric clinic, as observed, included the standard components.	100% 2/2	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
<p>Comments: 33. Quarterly reviews were completed in a timely manner for seven individuals requiring them. There were delays in the completion of quarterly clinical encounters for Individual #118 and Individual #380. 34. The Monitoring Team looks for nine components of the quarterly review. None of the examples included all the necessary components, with examples missing two to three components. 35. During the monitoring visit, the psychiatric clinic was observed for two individuals in the review group. In addition, psychiatry clinic was observed for 11 other individuals, not included in the review group. The clinics were well run and comprehensive. There was a need for improvement with regard to the use of data in psychiatric decision-making. As the psychiatrists were just beginning to</p>											

identify psychiatric indicators, it is expected that the use of anecdotal information will reduce with the availability of usable data.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: Frequency of implementation and prescriber review were not occurring as required. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
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 the completion of the assessments and the prescriber review of the assessments. For example, regarding Individual #380, the MOSES dated 9/29/17 was not reviewed by the prescriber until 12/13/17. The prescriber did not review the AIMS dated 9/29/17 until 2/19/18. In another example, regarding Individual #375, an AIMS was performed 2/6/18 with the next assessment 7/10/18 when an assessment should have been performed in May 2018. There was a MOSES performed 2/6/18, and a subsequent assessment should have been performed in August 2018.											

Outcome 12 – Individuals’ receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: Psychiatrist availability and follow-up was a strength of the San Antonio SSLC psychiatry program. These three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
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% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments:											

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	362	134	129	118	139	357	380	375	385
40	Daily medications indicate dosages not so excessive as to suggest goal	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	of sedation.	9/9									
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	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: All three indicators showed improved performance since the last review. The psychiatry department had taken action since then regarding polypharmacy-related activities and their efforts are reflected in these higher scores. These indicators will remain in active monitoring.					Individuals:						
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	71% 5/7		1/1	0/1	0/1	1/1	1/1	1/1		1/1
45	There is a tapering plan, or rationale for why not.	100% 7/7		1/1	1/1	1/1	1/1	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.	57% 4/7		1/1	1/1	1/1	0/1	1/1	0/1		0/1
<p>Comments:</p> <p>44. These indicators applied to seven individuals. Polypharmacy justification was appropriately documented in five examples. In some examples, the polypharmacy justification was not included in the clinical documentation, but rather located in the polypharmacy meeting minutes. The psychiatrists need to ensure that this information is included in the psychiatric clinical documentation.</p> <p>45. There was documentation for all individuals who met criteria for polypharmacy showing a plan to taper various psychotropic medications or documentation of why this was not being considered. This documentation was located either in the psychiatric documents or in the polypharmacy meeting minutes.</p> <p>46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for four of the</p>											

individuals meeting polypharmacy criteria. The polypharmacy committee meeting was observed during the visit. Psychiatry clinic staff organized and chaired the polypharmacy committee meeting. This meeting should be a facility level review of the polypharmacy regimens, and should be organized outside of psychiatry clinic. The psychiatry staff were doing their best to run an organized useful meeting and, as such, had made positive revisions to the polypharmacy meeting minutes, including more detail regarding the justification for the regimens.

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: Two of the six individuals who had good reliable data (indicator 5) were also making progress. Further, given that these two also met criteria for indicators 1-9, a deeper review is not required and, therefore, the remaining indicators in the psychology behavioral health sections of this report are not scored for them (Individual #362, Individual #375).

Of the four individuals who were not rated as making progress, one (Individual #134), did meet criteria for all of the other indicators in outcomes 1 and 2 (indicators 1-9) and all indicators met criteria in the deeper review (see the remainder of this report’s psychology/behavioral health sections). Thus, this individual, although not making progress, was deemed to be receiving psychology/behavioral services and supports as per the monitoring tool.

If there was no progress, San Antonio SSLC identified actions to take for half of the individuals. When actions were identified, the Center implemented those actions. This latter point has been the case for the past three reviews, too. **Therefore, indicator 9 will be moved to the category of requiring less oversight.** The other three indicators will remain in active monitoring.

Also, the behavioral health services department participated in determining treatment actions for interdisciplinary-related problems, such as one individual’s refusals to have podiatry examinations (Individual #244).

Individuals:

#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
6	The individual is making expected progress	25% 2/8	1/1	0/1		0/1	0/1	0/1	0/1	1/1	0/1
7	If the goal/objective was met, the IDT updated or made new	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A

	goals/objectives.										
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	50% 3/6	N/A	1/1		0/1	1/1	0/1	1/1	N/A	0/1
9	Activity and/or revisions to treatment were implemented.	100% 3/3	N/A	1/1		N/A	1/1	N/A	1/1	N/A	N/A

Comments:

6. Individual #375 and Individual #362's PBSP data indicated that they were progressing or maintaining low rates of target behaviors.

One individual who was not rated as making progress (Individual #134) did meet criteria for all of the other indicators in outcomes 1 and 2 (indicators 1-9) and all indicators met criteria in the deeper review (see the remainder of this report's psychology/behavioral health sections).

7. No goals were met. Therefore, indicator 7 was not applicable.

8. Individual #380, Individual #139, and Individual #134's PBSP data indicated that they were not progressing, however, their progress notes included actions to address their lack of behavioral progress. Individual #385, Individual #357, and Individual #118 also were not progressing as expected, however, there was no documentation in the progress notes that actions to address the lack of progress were identified.

9. For those individuals for whom actions were identified, the actions were implemented.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: Staff training criteria were met for indicator 16. This was a good improvement from the last review. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.					Individuals:						
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
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.	100% 6/6		1/1		1/1	1/1	1/1	1/1		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:											

Outcome 6 – Individuals’ progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: This indicator returned to 100% performance after last review was 17%. With sustained high performance, the Monitor will consider moving this indicator to the category of requiring less oversight after the next review. It will remain in active monitoring.					Individuals:						
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
19	The individual’s progress note comments on the progress of the individual.	Due to the Center’s sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.	100% 6/6		1/1		1/1	1/1	1/1	1/1		1/1
21	In the individual’s clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	Due to the Center’s sustained performance, these indicators were moved to the category of requiring less oversight.									
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.										
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.										
Comments:											

Outcome 8 – Data are collected correctly and reliably.											
Summary: San Antonio SSLC addressed the problems identified in the last review regarding data collection systems for PBSPs. As a result, indicators 26-29 scored at 100%. Moreover, there have been established goal frequencies and levels for this and for the past two reviews, too. Therefore, indicator 29 will be moved to the category of requiring less oversight. For two individuals who had reliable data, their goal frequencies and levels were achieved. Indicators 26, 27, 28, and 30 will remain in active monitoring.					Individuals:						
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 6/6		1/1		1/1	1/1	1/1	1/1		1/1
27	If the individual has a PBSP, the data collection system adequately	100%		1/1		1/1	1/1	1/1	1/1		1/1

	measures his/her replacement behaviors across all treatment sites.	6/6									
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 6/6		1/1		1/1	1/1	1/1	1/1		1/1
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% 6/6		1/1		1/1	1/1	1/1	1/1		1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	33% 2/6		1/1		1/1	0/1	0/1	0/1		0/1

Comments:

26-27. The data collection system for target and replacement behaviors was individualized, and flexible.

28. There were established measures of IOA, data collection timeliness, and treatment integrity across all treatment sites. These measures, although acceptable, could be improved by adding data from “natural” observations of target behaviors and staff responses (treatment integrity) and staff recording of the event (IOA, 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. Individual #385’s treatment integrity did not achieve the facility’s frequency objective. Individual #357’s IOA and DCT assessments also were below the frequency objective. Individual #139 and Individual #380’s PBSP data were not reliable (see indicator 5).

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 clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.					Individuals:						
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/12	0/2	0/2	0/1	0/1	0/1	0/1	0/2	0/2	N/A
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	8% 1/12	0/2	0/2	0/1	0/1	0/1	1/1	0/2	0/2	N/A
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/12	0/2	0/2	0/1	0/1	0/1	0/1	0/2	0/2	N/A
d.	Individual has made progress on his/her goal(s)/objective(s).	0%	0/2	0/2	0/1	0/1	0/1	0/1	0/2	0/2	N/A

		0/12									
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/12	0/2	0/2	0/1	0/1	0/1	0/1	0/2	0/2	N/A
<p>Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #357 – seizures/neurology, and osteoporosis; Individual #134 – diabetes, and constipation/bowel obstruction; Individual #347 – seizures, and other: elevated alkaline phosphatase; Individual #247 – cardiac: hyperlipidemia, and other: BPH; Individual #331 – cardiac disease: hypertension, and GI problems; Individual #352 – constipation/bowel obstruction, and other: anemia; Individual #36 – osteoporosis, and diabetes; Individual #370 – respiratory compromise, and cardiac disease; and Individual #178 – other: chronic kidney disease, and infections: LTBI).</p> <p>Some medical conditions required action plans, but did not require a goal/objective in which the individual or direct support professionals needed to engage to improve the individual’s health. These included: Individual #347 – other: elevated alkaline phosphatase; Individual #247 – other: BPH; Individual #331 – GI problems: colon polyps; Individual #352 – other: anemia; and Individual #178 – other: chronic kidney disease, and infections: LTBI.</p> <p>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 #352 – constipation/bowel obstruction.</p> <p>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.</p>											

Outcome 4 – Individuals receive preventative care.											
Summary: One of the nine individuals reviewed received the preventative care they needed. Improvements are needed. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. These indicators will continue in active oversight.					Individuals:						
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	20%	N/A	N/A	0/1	0/1	0/1	N/A	N/A	1/1	0/1

		1/5									
iii.	Breast cancer screening	50% 1/2	N/A	N/A	0/1	N/A	N/A	N/A	N/A	1/1	N/A
iv.	Vision screen	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
v.	Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
vi.	Osteoporosis	50% 4/8	0/1	N/A	0/1	1/1	1/1	0/1	0/1	1/1	1/1
vii.	Cervical cancer screening	100% 4/4	1/1	1/1	1/1	N/A	N/A	N/A	N/A	1/1	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	56% 5/9	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1
<p>Comments: a. The following problems were noted:</p> <ul style="list-style-type: none"> • On 9/22/17, an x-ray showed Individual #357 had osteopenia of the right clavicle. In addition, the individual received high-dose second-generation antipsychotics that increase the risk for loss of bone density. However, the AMA, dated 3/27/18, documented: "She is under 30 and not yet in the age range for preventive screening." Based on the September 2017 x-ray, there was an indication to obtain a DEXA scan. On 9/5/18, one year later, the PCP ordered a DEXA scan. • For Individual #134, the Center did not submit a vision assessment. • For Individual #347: <ul style="list-style-type: none"> ○ She had colorectal cancer (CRC) screening with the fecal immunochemical test (FIT). FIT is appropriate for individuals that are at average risk and have no family history of CRC. The family history for this individual was documented as unknown. Therefore, it was not clear that FIT was the most appropriate test based on CRC risk assessment alone (i.e., it might be appropriate be for other reasons, such as risk of sedation, but such clinical justification would need to be documented). ○ Per the AMA, dated 2/27/18, her "Next mammogram is due now." However, no evidence was submitted to show it was completed. ○ She had not had a DEXA scan completed, but the PCP provided no rationale, even though she was treated with two antiepileptic drugs (AEDs) strongly associated with osteoporosis. The AMA stated "Team to discuss if QCT [quantitative computed tomography] is desired." • On 3/24/16, Individual #247 had a positive result from the FIT screening, but the PCP did not address it until the AMA, dated 8/23/18, over two years later. • In August 2012, Individual #331's colonoscopy showed two polyps, one of which was an adenoma. In 2017, he should have had a repeat colonoscopy. Based on the documents submitted, he had not had follow-up surveillance. • Individual #352's DEXA scan should have been completed, but was pending. 											

- Individual #36 experienced fragility hip fractures, but based on documents submitted, he had not had a DEXA scan completed.
- In 2013, Individual #178 had a colonoscopy with normal results. However, the gastroenterologist recommended a repeat in five years, due to very poor preparation. Based on documentation submitted, the follow-up colonoscopy had not occurred.

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. In other words, the PCP should review the QDRR, provide an interpretation of the results, indicate if he/she agrees or disagrees, and discuss what changes can be made to medications based on this information, or state if the individual is clinically stable and changes are not indicated. This had occurred for some, but not all of the individuals reviewed.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
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: a. 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 did not meet generally accepted standards of care, and for some individuals reviewed, significant concerns were noted. For at least the past five reviews, the Center has shown poor compliance with these requirements. For the acute issues reviewed that required ED transfers or hospitalizations, PCPs generally assessed and provided individuals with treatment prior to the transfers in accordance with accepted standards. However, they often did not conduct needed follow-up. As indicated in the last report, the Center needs to prioritize improvements in these areas. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to	0% 0/7	N/A	0/2	N/A	0/1	0/1	N/A	0/2	0/1	N/A

	accepted clinical practice.										
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	0% 0/7		0/2		0/1	0/1		0/2	0/1	
c.	If the individual requires hospitalization, an ED visit, or an Infirmiry admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 5/5	1/1	N/A	N/A	N/A	N/A	N/A	1/1	2/2	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmiry admission, the individual has a quality assessment documented in the IPN.	80% 4/5	1/1						1/1	2/2	0/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	60% 3/5	1/1						0/1	2/2	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, this indicator 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.	100% 3/3	N/A						1/1	1/1	1/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	40% 2/5	0/1						0/1	1/2	1/1
<p>Comments: a. and b. For five of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses addressed at the Center, including: Individual #134 (lethargy on 4/10/18, and diarrhea on 5/22/18), Individual #247 (reactive airway disease on 4/15/18), Individual #331 (post-anesthesia hypoxia on 5/7/18), Individual #36 (emesis on 6/27/18, and hypoglycemia on 6/5/18), and Individual #370 (weakness and refusal to eat on 7/1/18).</p> <p>For none of the acute illnesses addressed at the Center did the PCPs assess the individuals according to accepted clinical practice.</p> <p>The following provide examples of concerns noted:</p> <ul style="list-style-type: none"> On 4/10/18, nursing staff documented that Individual #134 "appeared lethargic." The plan was for the PCP to see the 											

individual. On 4/10/18, the PCP did not document an assessment. On 4/11/18, the PCP conducted the evaluation for the AMA. It did not include any information related to lethargy.

On 4/12/18, the PCP documented that a couple of times in the last week, staff reported Individual #134 was lethargic. The physical exam only had a neurological component and stated that the individual's level of consciousness was variable and seemed to wax and wane. Her gait also had been noted to be abnormal, but also waxed and waned. The assessment was that these findings were behavioral.

The PCP conducted no follow-up. Subsequently, on 4/20/18, the individual was evaluated in the neurology clinic and her Depakote was tapered due to gait abnormalities and tremor.

- On 5/22/18, Individual #134 had three episodes of diarrhea. The PCP ordered Gatorade, but it was not clear that the PCP evaluated the individual.
- On 4/15/18, nursing staff documented that Individual #247 had frequent coughing episodes along with bilateral wheezing. The PCP was contacted, and ordered an albuterol nebulizer and chest x-ray in the morning.

This individual experienced wheezing over the weekend and had a chest x-ray done. On 4/16/18, the PCP should have seen him. However, it was not until 4/17/18, that the PCP evaluated the individual noting that the lungs were clear and the chest x-ray showed bilateral prominent markings, likely bronchitis or vascular congestion. The plan was to continue to monitor and follow-up as clinically indicated. The chest x-ray was not normal, but the PCP did not conduct follow-up.

- On 5/7/18, Individual #331 had dental treatment off campus at an ambulatory surgery center. During transport back to the Center, he required high-flow oxygen and frequent suctioning. Upon arrival to his home, he had low oxygen saturations. He was placed on two liters of oxygen via trach collar and his saturations increased. Excessive coughing and phlegm production were documented. The PCP was notified and gave orders for a stat chest x-ray, "frequent monitoring of vital signs," and head-of-bed elevation. On 5/8/18, the PCP evaluated the individual. The PCP described the individual as asymptomatic, awake with clear lung sounds. The PCP did not document follow-up with regard to the results of the chest x-ray. The assessment was transient hypoxia. The PCP indicated follow-up would occur as clinically indicated.
- On 6/26/18, Individual #36 underwent a radical orchiectomy. On 6/27/18, the PCP evaluated the individual. Several episodes of emesis and loose stools were reported. The PCP suspended laxatives, as well as narcotic pain medications.

On 6/28/18, the PCP evaluated the individual again. The PCP adjusted the individual's medications to address persistent emesis and increased gastric residuals. On 6/29/18, the PCP reevaluated the individual due to continued increased residuals. The PCP also documented that the individual had a nine-minute seizure the previous night, and was given buccal Ativan and started on oxygen due to decreased oxygen saturations. A chest x-ray was done, which was negative. The plan was to give the individual pro re nata (PRN, or "as needed") Reglan and wean him off of the oxygen. The PCP did not document any additional follow-up. On 7/6/18, the PCP documented the next evaluation.

- On 6/5/18, nursing staff documented that Individual #36 had capillary blood sugars of 47 and 42. Reportedly, he was awake, but had cool and clammy skin. The individual had Type 1 diabetes mellitus (T1DM) and was on nothing-by-mouth (NPO) status for a procedure the following day (ureteral stents).

The nurse administered intramuscular (IM) glucagon, based on a standing order. The on-call MD was contacted four times, but did not answer. Eventually, nursing staff contacted the Medical Director for clarification regarding the administration of seizure medications. There was no medical follow-up for this individual who had significant hypoglycemia and underwent general anesthesia for a surgical procedure.

- On 7/1/18, Individual #370 refused to eat breakfast, and was weak. Nursing documented that the individual accidentally poured soda on the floor while attempting to drink. She had an unsteady gait as well as slight wheezing. The oxygen saturation was 92%. The individual's mother was present at this time. Nursing staff documented notifying the PCP, labs were drawn, and a chest x-ray was completed. However, the PCP did not document a medical evaluation. On 7/2/18, the individual's mother reported that something was wrong. The individual was "out of it." The mother was concerned about low oxygen levels and low blood pressure. She requested that the PCP and case manager be notified about these concerns. Again, the PCP did not document an evaluation.

On 7/9/18, the PCP stated: "Notified of lab results from 07/01 evaluate." The assessment by the PCP was: "No acute lab or PE [physical exam] changes."

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 #357 (knee laceration on 9/25/18), Individual #36 (wound infection on 7/6/18), Individual #370 (head trauma on 4/27/18, and laceration on 6/14/18), and Individual #178 (human bite amputation on 4/17/18).

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

- It was positive to see that the following individual received timely acute medical care, and follow-up care: Individual #370 (laceration on 6/14/18).
- Often, PCPs did not specify when follow-up should occur, as they should have, but rather stated: "follow-up as clinically indicated." This issue needs to be corrected.
- On 9/25/18, the PCP documented that Individual #357 was transferred to the ED for evaluation of a laceration sustained during a fall. The laceration was repaired in the ED. According to the PCP's note: "substantial sedation with ketamine, Haldol and Benadryl" were needed to repair the laceration. On 9/26/18, the PCP saw her. The exam showed that the wound was intact with slight - moderate serous drainage and erythema. Clindamycin was started and the plan was to "follow-up as clinically indicated." It was not clear why this individual who had evidence of an early wound infection was not scheduled for follow-up to determine the effectiveness of the antibiotics.
- On 7/6/18, the PCP evaluated Individual #36 for an infected wound. The physical exam was pertinent for erythema and the presence of a purulent exudate. The individual was started on clindamycin. On 7/7/18, the PCP did not conduct and/or document follow-up. Around 8:00 p.m., on 7/7/18, nursing staff documented that the individual's scrotum was hard, swollen, and red. Medical evaluation was requested. On 7/8/18, the PCP documented that the wound was slightly firm with a serosanguinous drainage. The plan was to continue current treatment.

On 7/9/18, the PCP noted that the wound infection was improving on current therapy. On 7/10/18, nursing staff informed the PCP that the individual had emesis, was bleeding from the wound, and had a pulse of 102. The PCP gave orders for Tylenol. On

7/11/18, the individual continued to have emesis. The PCP evaluated him and noted that his abdomen was slightly distended and a foul-smelling discharge was expressed from the wound. The individual was transferred to the ED for evaluation.

On 7/19/18, Individual #36 returned to the Center after an admission for severe hyponatremia and wound infection. On 7/20/18 and 7/21/18, the PCP evaluated the individual.

On 7/24/18, nursing staff documented a sodium level of 129, which was a decrease from the individual's return. The PCP did not document additional follow-up.

On 7/26/18, the PCP documented that on 7/6/18, nursing staff informed him that the suprapubic stoma site was friable, and was oozing bright red blood from an abrasion. The PCP ordered silver nitrate. On 7/26/18, another PCP wrote the individual was being evaluated for a new skin lesion. The assessment was buttocks fissure and the plan was zinc oxide. The PCP indicated: Follow-up when healed or if worsens." It was documented that the individual had problems with gastric residuals and emesis that the primary provider managed.

On 8/2/18, the PCP documented a 14-day post admission note. The individual's serum sodium on that day was 129. No additional sodium levels were documented.

- On 4/27/18, the PCP documented that Individual #370 fell and hit her head. Due to the increased risk for intracranial bleeding secondary to Aspirin use, the PCP referred her to the ED for evaluation. On 4/28/18, another PCP evaluated the individual and documented that per nursing documentation the computed tomography (CT) of the head was negative. The physical exam was pertinent for facial ecchymosis. The plan was for nursing staff to monitor the individual.

There was no PCP follow-up. The next physician IPN entry, dated on 6/5/18, related to another transfer to the ED, on 6/4/18, for repair of a head laceration after a fall.

- On 4/17/18, the PCP documented that another individual bit Individual #178's right thumb and swallowed it. The physical exam showed amputation of the distal phalanx. The individual was transferred to the ED for evaluation and management of the amputation. The individual was transferred immediately, but the PCP did not conduct an assessment related to the potential transmission of infectious diseases. The PCP should have reviewed the vaccination records and serology for both individuals to determine if baseline serology or post-exposure prophylaxis were indicated. This information should be clearly documented in the records, but was not found.

On 4/19/18, Individual #178 returned to the Center, following surgical repair, and the PCP saw him upon his return. The plan was to continue antibiotics and check labs in the morning. On 4/20/18, the PCP saw him again. The plan was to continue wound care, antibiotics, and follow-up with orthopedics. On 4/30/18, the PCP saw him again, and documented he was doing well.

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

Summary: For the consultation reports reviewed, the PCPs generally indicated agreement or disagreement with recommendations, and did so in a timely manner.

Individuals:

It was good to see improvement with regard to PCPs writing IPNs related to consultation reports. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPA. These indicators will remain in active oversight.												
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178	
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 16/16	2/2	2/2	1/1	2/2	1/1	2/2	2/2	2/2	2/2	
b.	PCP completes review within five business days, or sooner if clinically indicated.	94% 15/16	2/2	1/2	1/1	2/2	1/1	2/2	2/2	2/2	2/2	
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	94% 15/16	2/2	2/2	1/1	2/2	1/1	2/2	2/2	1/2	2/2	
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	94% 15/16	2/2	2/2	1/1	2/2	1/1	1/2	2/2	2/2	2/2	
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	
<p>Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #357 for gynecology on 8/22/18, and neurology on 5/25/18; Individual #134 for neurology on 7/13/18, and neurology on 4/20/18; Individual #347 for gynecology on 8/22/18; Individual #247 for dermatology on 9/10/18, and neurology on 7/13/18; Individual #331 for pulmonary on 8/24/18; Individual #352 for urology on 8/22/18, and cardiology on 4/23/18; Individual #36 for dermatology on 9/10/18, and epileptology on 5/15/18; Individual #370 for neurology on 8/17/18, and sleep disorders on 7/5/18; and Individual #178 for orthopedics on 5/2/18, and podiatry on 8/30/18.</p> <p>Of note, in the few months prior to the review, it appeared that Center staff corrected the issues the Monitoring Team noted in the last report where they were scanning consultation reports into IRIS as opposed to writing IPNs, and the Medical Director, as opposed to the PCPs, was reviewing/processing most of the consultation reports. The Monitoring Team appreciated Center staff's efforts in this regard.</p> <p>a. For the consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations, and provided rationales for disagreements.</p> <p>b. Only one of these reviews did not occur timely (i.e., the one for Individual #134 for neurology on 4/20/18).</p>												

c. For Individual #370, the sleep specialist noted that the sleep study did not show obstructive sleep apnea, but the study was limited due to a lack of rapid eye movement (REM) sleep. The consultant indicated it would be too difficult to obtain another study. The recommendation was for the individual to sleep with the head-of-bed (HOB) elevated. The PCP had not summarized any of this in the IPN.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exception of the following: Individual #352 was diagnosed with a neurogenic bladder. The recommendation was to have daily catheterization and bladder irrigation. The PCP agreed with this recommendation. The Center’s response to the Monitoring Team’s document request included the orders written for follow-up appointments, but there was no order written for daily catheterization and irrigation.

e. The PCP did not refer the recommendation related to daily catheterization and bladder irrigation to Individual #352’s IDT. Given the invasive nature of the treatment, the PCP should have notified the IDT, so that proper supports could be implemented.

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

Summary: 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 PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals:									
			357	134	347	247	331	352	36	370	178	
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.	28% 5/18	0/2	0/2	0/2	0/2	1/2	1/2	0/2	1/2	2/2	

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #357 – seizures/neurology, and osteoporosis; Individual #134 – diabetes, and constipation/bowel obstruction; Individual #347 – seizures, and other: elevated alkaline phosphatase; Individual #247 – cardiac: hyperlipidemia, and other: BPH; Individual #331 – cardiac disease: hypertension, and GI problems; Individual #352 – constipation/bowel obstruction, and other: anemia; Individual #36 – osteoporosis, and diabetes; Individual #370 – respiratory compromise, and cardiac disease; and Individual #178 – other: chronic kidney disease, and infections: LBTI).

a. For the following individuals’ chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #331 – cardiac disease: hypertension; Individual #352 – constipation/bowel obstruction; Individual #370 – respiratory compromise; and Individual #178 – other: chronic kidney disease, and infections: LBTI. The following provide examples of concerns noted:

- Individual #357 was at medium risk for seizures/neurology. According to the AMA, the individual was seizure free on

Trileptal. The plan was to continue the current medication regimen, monitor labs, and schedule follow-up for the neurology clinic.

On 3/16/17, the individual was admitted, but it was not until 5/25/18, that the initial neurology evaluation was completed. The neurologist documented that since admission, the individual had no seizures. It was also noted that she was diagnosed with cerebellar degeneration, "probably with neuroimaging studies." There was no documentation of a physical examination to indicate physical findings seen in cerebellar degeneration. There also was no discussion of conducting an evaluation to determine the etiology of the cerebellar degeneration in an individual who experienced multiple falls. The plan was to continue medications and follow-up in one year. It was noteworthy that on 12/8/17, the individual was seen in the ED for a head laceration. At that time, a CT scan of the head showed a midline pericallosal lipoma with some dystrophic calcifications around the borders. There was no mass effect. These findings were also present in a CT scan done in August 2017. This was not documented in the AMA, interval medical reviews, or the neurology consult.

The PCP documented in the AMA that the CT of the head was normal. While there were no acute changes, the AMA should have documented the diagnosis of the ventricular lipoma and the plan to address it. The PCP commented in the neurology consult IPN that the psychiatrist would attempt to obtain the seizure history from the family. However, there was no evidence that the PCP made any efforts to contact the father to obtain additional information.

This individual had multiple falls and self-injurious behavior (SIB), such as head banging documented in the records. The PCP made no IPN entries related to this. The diagnosis of cerebellar degeneration warranted further evaluation through physical examination and possibly more specific and sensitive neuroimaging studies. Additionally, there should have been further assessment of the lipoma and referral to a specialist for evaluation.

- Individual #357 was at medium risk for osteoporosis, and had a Vitamin D deficiency. The individual was treated with cholecalciferol. The PCP moved this diagnosis to the inactive list, even though she received daily Vitamin D supplementation.

Per the lab reports submitted, on 1/29/18, the last Vitamin D level was 32. This was a borderline optimal level for an individual with Vitamin D deficiency, who required supplementation and had evidence of osteopenia on an x-ray, dated 9/22/17. The osteopenia was documented in the interval medical review, dated 10/24/17. The PCP did not address the osteopenia in the March 2018 AMA.

In the interval medical review, dated 9/19/18, the PCP noted that on 9/5/18, a bone mineral density test was ordered due to chronic AED use. While it was good to see that the DEXA was ordered, the diagnoses of Vitamin D deficiency and osteopenia combined with long-term AED use should have prompted ordering the DEXA in 2017.

- The PCP documented in the AMA that Individual #134 weighed 193 pounds with a body mass index (BMI) of 32.1. The AMA also documented an A1c of 5.2. The PCP determined that the individual was at medium to high risk for the development of metabolic syndrome. Under the risk assessment, it was noted that a calorie restriction was in place and increased physical activity should be encouraged. The PCP did not list obesity as an active diagnosis. There was no specific plan related to dietary interventions or how physical activity would be increased.
- According to the AMA, dated 4/27/18, Individual #347's last recorded seizure was in 2011. She experienced status epilepticus

at that time. However, the IRRF documented seizure activity on 2/8/18 and 2/28/18. Ativan was administered on 2/8/18. The AMA did not reflect accurate seizure data. The Summary/Plan only stated that current medications would be continued and the individual would be referred to the neurologist as needed. The Assessment/Plan should provide information on the overall status, such as seizure frequency, and the date of the last seizure. The timeframe for the next neurology follow-up should be specified. According to the psychiatry evaluation, the last neurology clinic the individual attended was on 1/26/18.

- For Individual #347, the AMA did not discuss the problem of chronic elevation in alkaline phosphatase. On 4/6/18, the Clinical Pharmacist documented a clinical intervention stating that this was discussed with the PCP. According to the Clinical Pharmacist, an elevated alkaline (ALK) was not typically a medication effect. The PCP documented in the interval medical review, dated 11/8/17, that the elevation was "due to meds." There was no further evaluation of this.

It should be noted that mild to moderate elevations (<4 times the upper limit of normal) might be seen in a number of hepatic and non-hepatic conditions. The value might vary and be normal early in the disease process. There was no attempt to determine the etiology of the elevation. There are well-established algorithms established to evaluate elevated alkaline phosphatase levels.

- The pharmacist made a recommendation for Individual #247 to start a statin based on the risk score. Per the clinical intervention, dated 9/12/18, after the physician entered the order, the atorvastatin adverse effect flagged due to a previous chemical hepatitis associated with atorvastatin. The QDRR was amended and the PCP discontinued the order.

Of note, the AMA, dated 8/23/18, listed atorvastatin as an active medication. Hyperlipidemia was discussed in two sections. In the Active Problems section, the PCP made no comment related to the atorvastatin being discontinued due to an ADR. Under the Summary, it was noted that the individual's cholesterol remained low and a statin would be considered if the cholesterol became abnormal. Atorvastatin was listed as an allergy in the AMA. There was no discussion of the previous ADR. There was also no discussion of the arteriosclerotic cardiovascular disease (ASCVD) risk score.

The interval medical review, dated 5/23/18, documented that the atorvastatin was discontinued on 12/18/17. It also stated that a statin was not indicated due to low cholesterol and an associated increased mortality with subnormal cholesterol levels.

- Under the inactive problem list, Individual #247's PCP discussed the history of prostatitis and BPH and noted that the prostate-specific antigen (PSA) was again elevated and a referral would be made to urology. The Summary section included BPH as a diagnosis, and noted that the individual had not had any recent urinary tract infections (UTIs) and Flomax would be continued. There was no discussion of the elevation in PSA. On 9/11/18, the PCP entered an addendum stating the family agreed to continue PSA testing.

The AMA should include an Assessment and Plan for each active medical problem. The current status of the problem should be listed as well as the plan to address the problem. Fragmenting the assessment and plan into multiple sections makes it difficult to determine the actual plan of care. The PCP stated in one section that a urology referral would be made. However, there was no evidence that this was done.

- Individual #331's AMA, dated 5/23/18, documented in the Active Problem section the diagnosis of tubular adenoma and the need to repeat the colonoscopy in 2017. However, this diagnosis was not included in the Summary section. The Health Maintenance section noted that the colonoscopy was due in 2017, and was re-ordered in April 2018. The Assessment/Plan

section of the AMA should have included the diagnosis of colon polyps/tubular adenoma and the date for the next colonoscopy.

Three interval medical reviews were completed, none of which documented the diagnosis of tubular adenoma and the need to repeat the colonoscopy in 2017. In fact, the interval medical review, dated 8/15/18, stated the next colonoscopy was due in August 2022. This contradicted the statements included in the AMA regarding a colonoscopy being ordered in April 2018. At the time the Center responded to the document request, the repeat colonoscopy, which was due in 2017, had not been completed.

- According to Individual #352's AMA, the individual's anemia was due to blood loss and the plan was to continue iron supplementation, monitor the complete blood count (CBC), and reschedule the gastroenterology (GI) consult.

Per the interval medical review, dated 8/10/18, on 3/22/18, the PCP discontinued iron. On 3/23/18, the last CBC was done. The hemoglobin and hematocrit were normal, but the mean corpuscular volume (MCV) remained low at 78. There was no follow-up CBC in the records to ensure that the individual's hemoglobin and hematocrit remained normal off iron, and there was no GI consult submitted in the records reviewed.

- Individual #36's AMA, dated 2/20/18, did not discuss osteoporosis. As a potential risk for restraint, the PCP noted that the possibility of osteoporosis did exist, but because the individual was not a candidate for antiresorptive therapy, no DEXA scan was obtained.

A CT, done on 3/9/18, showed acute and subacute right femur fractures. In the interval medical review, dated 5/31/18, the PCP considered metabolic bone disease and indicated that a DEXA would now be done. In the very same document under preventive care, the PCP documented that no DEXA would be pursued due to positioning problems and adverse effects of medications.

The Center did not submit any endocrinology consults. Per the IPN related to the endocrine consult done on 8/20/18, the individual was seen for evaluation of osteoporosis. Recent imaging showed prior hip and femoral fractures. The recommendation was to complete a workup and follow-up in the clinic to determine treatment with consideration given to intravenous (IV) risendronate.

In its comments on the draft report, the State disputed the Monitoring Team's statement that: "The Center did not submit any endocrinology consults," and stated: "The Endocrinology Consult for 8-20-18 was submitted and is evidenced in TX-SA-1810-II.59.... .pg 8 of 20." The Lead Monitor and the physician member of the Monitoring Team reviewed the document the State referenced. It was not an endocrinology consult, but rather, it was the IPN that the Monitoring Team referenced in its draft report in which the PCP summarized the endocrinology consultation report. The consultation report would be produced and signed by the endocrinologist.

- According to Individual #36's AMA, the individual had T1DM and was treated with insulin. It stated that lab data indicated ongoing deterioration of renal function. The plan included appropriate insulin, referral to dietary, A1c<8, blood pressure of <140/90, low density lipoprotein (LDL) <70, annual urine micro-albumin/creatinine ratio, and referral to nephrology for "ongoing deterioration of renal function."

The documents reviewed did not include any evidence of a recent referral to nephrology for evaluation of “ongoing deterioration of renal function.” There was also no documentation of a micro-albumin/creatinine ratio. Proteinuria was documented several times in a basic urinalysis.

- Individual #370 had an internal defibrillator for treatment of ventricular tachycardia. She also was diagnosed with hypertension. According to the AMA, the cardiologist saw the individual every six months. Cardiology consults were not submitted, but there was documentation that a cardiology consult was done in March 2018. Therefore, the follow-up should have occurred in September 2018. The individual was receiving amiodarone for management of her arrhythmia. There was no discussion in the AMA or interval medical reviews related to the monitoring that is required with the use of the drug. The AMA plan should clearly outline how the individual would be monitored for amiodarone toxicity (frequency for obtaining CXR, LFTs, TFTs, etc.). Stating that cardiology follows the individual is not adequate particularly if there is not documentation of important issues such as amiodarone toxicity.

Additionally, the neurologist made several requests for the individual to have cardiology follow-up. No documentation was submitted to indicate that the six-month follow-up occurred.

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, for most of the IHCPs reviewed, documentation was found to show implementation of those few 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	357	134	347	247	331	352	36	370	178
a.	The individual’s medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	83% 5/6	1/1	N/A	1/1	1/1	N/A	N/A	2/2	0/1	N/A
Comments: a. As noted above, individuals’ IHCPs often did not include a full set of action steps to address individuals’ medical needs. However, the action steps assigned to the PCPs generally were implemented. The exception was for the following: Individual #370 – cardiac issues (i.e., the cardiology evaluation in September).											

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	357	134	347	247	331	352	36	370	178	
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	Not rated (N/R)										
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R										
Comments: a. and b. The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.												

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.												
Summary: Given the timely completion of QDRRs during this review and the past two reviews (Round 12 – 100%, Round 13 – 100%, and Round 14 - 94%), Indicator a will move to the category requiring less oversight. Improvement is needed with regard to the quality of the QDRRs, particularly with regard to recommendations related to concerning lab values, and the evaluation of individuals' risk for metabolic syndrome. If the Center maintains improvements with regard to practitioners' documentation of their decisions about agreement or disagreement with the Clinical Pharmacist's recommendations, after the next review, Indicator c might move to the category of less oversight.			Individuals:									
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178	
a.	QDRRs are completed quarterly by the pharmacist.	94% 17/18	2/2	1/2	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;	50% 9/18	0/2	2/2	1/2	2/2	2/2	0/2	0/2	0/2	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	50% 3/6	1/2	0/2	N/A	N/A	N/A	N/A	N/A	2/2	N/A
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 10/10	2/2	2/2	2/2	N/A	N/A	N/A	N/A	2/2	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	75% 6/8	1/2	0/1	1/1	2/2	1/1	N/A	N/A	1/1	N/A
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: b. For a number of individuals, the most recent lab data should have resulted in recommendations, but the Clinical Pharmacist did not make them.

At times, the Clinical Pharmacist indicated that individuals were at low risk for metabolic syndrome without the necessary data to draw this conclusion (e.g., waist circumference).

c. For the individuals reviewed, it was good to see that prescribers reviewed QDRRs timely. As noted in previous reviews, San Antonio SSLC has had problems printing QDRRs that include signatures and responses to the recommendations. Other SSLCs are not having this same problem. The Pharmacy Director has attributed this to the PCPs. Many of the QDRRs included screen shots with multiple actions and signatures. These screen shots do not reproduce well and are difficult and sometimes impossible to read.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was presented to show they implemented them. For Individual #357, and Individual #134, documentation was not presented to show whether or not the PCP agreed with one or more of the recommendations.

Of note, for Individual #370, the Clinical Pharmacist made a recommendation to complete a work-up for prolonged hyponatremia. The PCP responded that a work-up for borderline hyponatremia would not be helpful. This individual had long-term hyponatremia that had never been appropriately evaluated. The diagnosis of hyponatremia was assumed to be due to valproic acid. There are numerous potential causes of hyponatremia and further investigation was warranted.

e. As noted with regard to Outcome #1, the Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy’s review of new orders. Until it is resolved and the Monitoring Team is able to identify the full scope of new medications requiring interventions, this indicator is not being rated.

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. A number of individuals reviewed had deteriorating dental health. However, their IDTs had not set forth clinically relevant, achievable goals or corresponding reasonable plans to address their dental needs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
<p>Comments: a. and b. For many of the individuals reviewed, dental goals were non-specific, and did not address clinically relevant ways in which individuals could improve their dental health, or that staff could assist them to do so. For example, goals read: “dental care to meet needs,” or “improve oral hygiene from poor to fair.” A number of individuals’ dental health was deteriorating or was otherwise cause for concern, but IDTs had not developed plans to address individuals’ needs. For example:</p> <ul style="list-style-type: none"> • Although it was unclear whether or not oral hygiene ratings provided reliable data, in March 2017, Individual #357 reportedly had good oral hygiene. In November 2017 (i.e., the last rating available), it worsened to poor. Her IDT had not set forth a clinically relevant, achievable goal or corresponding reasonable plan to address her dental needs. • On 4/25/18, Individual #134 went to the dental clinic for an appointment. Based on dental notes, she had poor oral hygiene with “gross amounts of food debris.” Again on 9/17/18, dental staff noted poor oral hygiene with a thick layer of plaque on all tooth surfaces. Her goal/objective was: “Dental care to meet needs.” • Individual #347’s periodontal disease had worsened to Stage 4, and she had poor oral hygiene with heavy and generalized plaque. Her IDT had not set forth a clinically relevant, achievable goal or corresponding reasonable plan to address her dental 											

needs.

- Even though Individual #178's IDT identified that he needed to improve his oral hygiene "to continue at ground texture and to avoid unnecessary extractions due to possible infection," they did not set forth a clinically relevant, achievable goal or corresponding reasonable plan to address his dental needs. He had poor oral hygiene, including heavy calculus and plaque, and needed TIVA for dental care.

The Monitoring Team will continue working with State Office on this issue so that State Office can provide more guidance to the Centers. A good way to think about it, though, is: "what would the dentist tell the individual he/she or staff should work on between now and the next visit?" For different individuals, the causes of their dental problems are different, and so the solution or goal should be tailored to the problem. For example, should an individual reduce the amounts of sugary snacks he/she consumes, should an individual brush his/her teeth twice a day for two minutes instead of once a day, should a goal revolve around the individual tolerating tooth brushing for 30 seconds leading up to an eventual two minutes? These are the type of questions IDTs should be asking themselves when deciding upon a goal.

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 generally 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	357	134	347	247	331	352	36	370	178
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.	N/R									
Comments: c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.											

Outcome 5 – Individuals receive necessary dental treatment.	
Summary: During this review and the last one, individuals at medium or high risk for caries received at least two topical fluoride applications per year. If the Center sustains this improvement, after the next review, Indicator d might move to the	Individuals:

category requiring less oversight. At this time, the remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	56% 5/9	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	67% 6/9	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	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% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 2/2	N/A	1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
Comments: a. through f. None.											

Outcome 7 - Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
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, this indicator 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: Since the last review, the Center improved its performance with regard to the inclusion of measurable action steps related to suction tooth brushing in			Individuals:								

applicable individuals' ISPs. In addition, for the three individuals reviewed that needed suction tooth brushing, staff had documented completion of it in accordance with the measurable action step. However, all three individuals had either poor or fair oral hygiene, and their IDTs had not identified the frequency of monitoring of the technique and Dental Department staff were not completing monitoring. QIDPs also were not summarizing and analyzing data in the monthly integrated reviews. These indicators will continue in active oversight.											
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 3/3	N/A	N/A	N/A	1/1	1/1	N/A	1/1	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 3/3				1/1	1/1		1/1		
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3				0/1	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% 0/3				0/1	0/1		0/1		
<p>Comments: a. It was good to see that for the three applicable individuals, IDTs included suction tooth brushing strategies/plans in their ISPs/IHCPs.</p> <p>b. Based on documentation submitted, for each of the individuals, staff completed the suction tooth brushing according to the schedule.</p> <p>c. Based on documentation submitted, the Dental Department staff did not conduct monitoring of staff's implementation of suction tooth brushing for quality, as well as safety. In addition, ISP action plans did not define the frequency expected to meet the individuals' needs.</p> <p>Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." Although it was unclear whether or not oral hygiene ratings provided reliable data, at their most recent dental visits, these individuals had poor (i.e., Individual #331) or fair (i.e., Individual #247, and Individual #36) oral hygiene. Based on these ratings, frequent monitoring might have been necessary to ensure that staff were completing the tooth brushing correctly.</p>											

Outcome 9 – Individuals who need them have dentures.	
Summary: These indicators will continue in active oversight.	Individuals:

#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	22% 2/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. For most individuals reviewed with missing teeth, the Dental Department indicated that the individual had full functional dentition as the clinical justification for not recommending dentures. Without further explanation, this did not provide sufficient justification. For example, Individual #370 had nine missing teeth, and Individual #178 had 17 missing teeth. It was unclear how they had full functional dentition.											

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: These indicators will remain in active oversight.						Individuals:					
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
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. In the months prior to the review, State Office provided training to all of the Centers on the development of acute care plans. During this round of reviews, the Monitoring Team is working with State Office on ensuring Centers provide the											

correct documentation for review of acute care plans. Given the timing of the San Antonio SSLC review, the Center was in the initial stages of implementing the revised acute care plan template/process. It was decided that the Monitoring Team would not search for needed acute care plans that might not exist throughout the preceding six months. However, as a result of the ongoing systems issue since the implementation of IRIS, these indicators do not meet criteria. Center staff should continue to work with State Office to correct the issues. By the time of the next review, the Monitoring Team plans to conduct a full review of acute care plans.

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	357	134	347	247	331	352	36	370	178
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	17% 3/18	0/2	0/2	0/2	1/2	0/2	1/2	1/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #357 – constipation/bowel obstruction, and seizures; Individual #134 – choking, and weight; Individual #347 – circulatory, and osteoporosis; Individual #247 – respiratory compromise, and constipation/bowel obstruction; Individual #331 – aspiration, and GI problems; Individual #352 – infections, and constipation/bowel obstruction; Individual #36 – respiratory compromise, and GI problems; Individual #370 – falls, and cardiac disease; and Individual #178 – dental, and skin integrity).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals’ progress or lack thereof: Individual #247 – constipation/bowel obstruction, Individual #352 – infections, and Individual #36 – respiratory compromise.

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 6 – Individuals’ ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.												
Summary: Nurses often did not include interventions in IHCPs to address individuals’ at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals’ risks. These indicators will remain in active oversight.				Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178	
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% 0/4	N/A	0/1	N/A	N/A	N/A	N/A	0/1	0/1	0/1	
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).	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	
<p>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.</p> <p>a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not 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, or that nursing interventions were implemented thoroughly. The lack of measurable action steps impacted these findings significantly. The only exception was for Individual #36’s respiratory compromise IHCP.</p> <p>b. The following examples provide information about IDTs’ responses to the need to address individuals’ risks:</p> <ul style="list-style-type: none"> Individual #134’s weight IHCP included a goal for her to lose weight: “[Individual #134] will decrease weight in the next year AEB [as evidenced by] 1>2 # [pounds] next year.” A Nutrition Comprehensive Assessment, dated 3/27/18, stated: "collaborative monitoring with RNCM who will monitor weights and notify dietitian and PCP of weight changes of > 5lbs in one month or more than a 5% change in weight over 1 month, >7.5% change in 3 months, or >10% change in 6 months." Based on documentation submitted, in April 2018, her weight decreased by more than five pounds in one month (i.e., on 3/13/18, she weighed 193 pounds, and on 4/16/18, she weighed 181.4 pounds, which represented a loss of 11.6 pounds); and between April and May 2018, she lost 13 pounds (i.e., a decrease from 181.4 pounds to 168.4 on 5/7/18). She continued losing weight, and, 												

on 8/23/18, she weighed 163 pounds, with an increase to 167 pounds in September 2018. Given the goal, as well as the nutritional assessment, this weight loss appeared to be significant and unplanned. In addition, based on documents provided, it appeared Individual #134, at times, took other individuals' food and consumed it. In fact, a targeted behavior in her PBSP was "food stealing." Based on the ISPAs submitted, her IDT did not meet to discuss her weight loss.

- In July 2018, Individual #36 had 12 episodes of emesis. Although the goal/objective the IDT developed was not clinically relevant, it stated: "[Individual #36] will maintain his GI condition (gastroparesis) during the next year AEB < 8 reported emesis." Twelve episodes of emesis in one month should have triggered IDT action. However, based on the ISPAs submitted, the IDT did not meet to discuss the frequency of the emesis, amount of emesis, or how it correlated with his residuals.
- From between September 2017 and September 2018, Individual #370 fell numerous times: 2017: September – 7, October – 12, November – 3, and December – 3; and 2018: February – 2, March – 3, April – 1, May – 1, June – 5, July – 1, August – 1, September – 3, and October – 2. She also had a number of injuries related to her falls:
 - On 1/20/18, while on an outing, she fell and sustained a cut to her left forehead, requiring Dermabond to close a 1.5-centimeter (cm) laceration.
 - On 3/12/18, she sustained a fracture to the proximal right femur. In 2017, she had fractures of her left forearm (i.e., 9/5/17), and her distal radial metaphysis and ulnar styloid (i.e., 7/10/17).
 - On 4/27/18, a fall resulted in a traumatic hematoma on her forehead, requiring the use of Dermabond.
 - On 6/4/18, she sustained a laceration to the back of her head, requiring four staples. The IDT documented she was not wearing slip socks.
 - On 6/14/18, she fell when she slipped on water in the shower room. Reportedly, staff supported her, but she still struck the back of her head on the floor, and sustained a laceration. From 6/14/18 to 6/18/18, she was hospitalized for bronchitis and evaluation of her falls, including a STAT magnetic resonance imaging (MRI) of her spine due to the frequent falls.

On 6/4/18, Individual #370's IDT met to discuss her serious injury. The IDT discussed how she fell and hit her head on the foot board of the bed. The IDT indicated that: "she was on her tippy toes, lost her balance, as she was reaching into her closet (the top shelf) for an item." The IDT decided to remove the shelf; have staff remind her to wear her non-slip socks, noting she should have them on prior to getting out of bed (e.g., to use the restroom during the night, and in the morning as she gets up for the day); and that staff should follow the PNMP. The IDT made no change to the IRRF or IHCP, and did not document a review of the existing interventions to determine if they were working as written. For example, the IDT did not review and analyze data related to her compliance with wearing her non-slip socks, or staff's compliance with following the PNMP. The next ISPA, dated 6/11/18, related to her level of supervision. At this meeting, the IDT did not discuss and/or document any follow-up regarding decisions made at the previous meeting (e.g., removal of the shelf, her compliance with wearing her non-skid socks, or PNMP implementation). On 6/13/18, the IDT met to discuss her falls on 4/27/18, 5/30/18, and three in June 2018. The IDT agreed on the following actions: transportation on campus by the people mover, and a new stepper, and grab bar. The IDT did not conduct a review of the IRRF or IHCP. On 6/20/18, the IDT held a post-hospitalization ISPA meeting. The record discussed her discharge diagnosis, and treatment while in the hospital. The IHCP or IRRF were not reviewed.

- On 4/17/18, Individual #178's right thumb was amputated when another individual bit him. The individual was transferred to the hospital, where he was admitted. The physical exam showed amputation of the distal phalanx. Based on documentation submitted, the IDT did not hold an ISPA meeting to discuss this traumatic event, and to put plans in place to address the

individual's needs.

Outcome 7 – Individuals receive medications prescribed in a safe manner.											
Summary: For at least the two previous reviews, as well as this review, the Center did well with the indicator related to nurses administering medications according to the nine rights. However, given the importance of this indicator to individuals' health and safety, it will continue in active oversight until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
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% 5/5	N/R	N/R	1/1	N/R	1/1	N/R	1/1	1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/A									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	40% 2/5	N/A	N/A	N/A	0/1	0/2	N/A	2/2	N/A	N/A

e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	60% 3/5			1/1		0/1		0/1	1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	80% 4/5			1/1		1/1		0/1	1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper 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 five individuals, including Individual #347, Individual #331, Individual #36, Individual #370, and Individual #178.

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

d. Regarding respiratory assessments as part of medication administration, the following summarizes the findings:

- Individual #247's IHCP, dated 8/23/18, required that prior to medication administration and flushes, nurses conduct respiratory assessments, including lung sounds. Based on the documentation provided, for the majority of assessments completed, nurses did not consistently complete anterior and posterior lung sound assessments.
- For Individual #331, who had a tracheostomy, nurses performed anterior lung sound assessments prior to and after medication administration, but did not perform posterior lung sound assessments. His IHCP did not define the parameters for lung sound assessments, but an undated physician's order indicated only anterior lung sounds. Based on review of other documents requested on site, no clinical justification/rationale for nurses not completing posterior lung sounds was found.
- Individual #36's aspiration/respiratory IHCP included an action step for the completion of a respiratory assessment prior to

medication administration. Based on review of documentation for August and September 2018, nurses performed anterior breath sounds prior to medication administration.

Based on observation, the medication nurse assessed the individual's anterior lung sounds prior to and after medication administration. A physician's order indicated nurses should complete only anterior breath sound assessments. An ISPA documented the IDT's discussion regarding lung sounds, and the need to complete them anteriorly only due to his vomiting when staff raised him up for the nurse to listen to his posterior lung sounds. This provided the clinical justification for the IDT's decision.

f. For Individual #331 and Individual #36, the medication nurses did not follow the PNMPs with regard to positioning.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was the nurse for Individual #36 that allowed her hand to come into direct contact with the pill.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.												
Summary: It was good to see continued improvement with regard to individuals being referred to the PNMT, when needed. Overall, though, 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	357	134	347	247	331	352	36	370	178	
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% 0/12	0/1	0/2	0/1	0/1	0/2	0/2	N/A	0/1	0/2	
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/12	0/1	0/2	0/1	0/1	0/2	0/2		0/1	0/2	
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/1	0/2	0/1	0/1	0/2	0/2		0/1	0/2	
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/1	0/2	0/1	0/1	0/2	0/2		0/1	0/2	
	v. When there is a lack of progress, the IDT takes necessary	0%	0/1	0/2	0/1	0/1	0/2	0/2		0/1	0/2	

	action.	0/12									
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;	83% 5/6	0/1	N/A	1/1	1/1	N/A	N/A	2/2	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	0/1			0/2	0/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6	0/1		0/1	0/1			0/2	0/1	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6	0/1		0/1	0/1			0/2	0/1	
	v. Individual has made progress on his/her goal/objective; and	0% 0/6	0/1		0/1	0/1			0/2	0/1	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1		0/1	0/1			0/2	0/1	

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #357 – choking; Individual #134 - falls and choking; Individual #347 – fractures; Individual #247 – skin integrity; Individual #331 – fractures, and GI problems; Individual #352 - skin integrity, and falls; Individual #370 – choking; and Individual #178 – choking, and falls.

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

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 goals/objectives were included. These areas of need included for: Individual #357 – falls; Individual #347 – weight; Individual #247 – respiratory compromise; Individual #36 – fractures, and GI problems; and Individual #370 - falls.

The following individual should have been referred to the PNMT, but was not:

- When she met criteria, Individual #357's IDT did not refer her to the PNMT. Although the data related to falls varied considerably across sources, it appeared the individual met criteria in December 2017 (i.e., she fell five times in November, and five times in December). Again, between June 2018 and September, she fell numerous times (i.e., she fell four times in May, three times in June 3, four times in July, three times in August, and four times in September). Although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined at a minimum according to the following qualifying event/threshold..." (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. This individual's continuing

falls placed her at significant risk of harm.

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 clinically relevant and measurable goals/objectives, integrated progress reports with data and analysis of the data generally were 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: Data generally were not included in monthly integrated reviews to confirm the implementation of PNM action steps. Often, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. For the individuals reviewed whom the PNMT discharged, documentation was not presented to show that the IDT and the PNMT held ISPA meetings, during which they shared comprehensive discharge information. At this time, these indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	20% 2/10	0/1	1/2	0/1	1/2	N/A	0/1	0/2	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	N/A	N/A	0/1	N/A	N/A	0/2	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. Monthly integrated reviews often did not include specific information or data about the status of the implementation of the action steps.

- b. The following provide examples of findings related to IDTs' responses to changes in individuals' PNM status:
- It was good to see that on 4/4/18, Individual #134's IDT met to discuss concerns that her mother expressed about her eating/choking risk. The initial lethargy noted at the time of her admission had improved, and the IDT found no other indications of changes related to her functioning at meal times.

- Individual #247's IDT did not develop and implement strategies to prevent skin breakdown during hospitalizations. From 3/27/18 to 4/17/18, he was hospitalized for right lower lobe pneumonia and acquired a Stage II decubitus at the inter-gluteal cleft and another Stage II to the right buttock at the coccyx level adjacent to the cleft, and PEG placement on 4/14/17. He was again in the hospital from 4/21/18 to 4/26/18, for continued pneumonia. He was referred to the PNMT on 4/18/18, but other than reporting the incidence of pressure ulcers, the IDT did not address a develop and implement a plan to prevent them in the future.
- On a positive note, Individual #247's IDT addressed findings from a modified barium swallow study (MBSS) and increased his oral intake.
- On 1/18/18, and 3/12/18, Individual #352 experienced pressure ulcers on his left posterior hip/buttock. Although nurses developed acute care plans to address the pressure ulcers, the IDT did not develop an IHCP to prevent their recurrence.
- In June 2018, Individual #370's IDT held ISPA meetings to discuss an increase in her falls. Although the IDT added interventions to the PNMP at that time, the etiology of these falls remained unknown. In March 2018, she had met PNMT discharge criteria, but they considered their ongoing review of fall videos a means for them to track her falls and work to identify the cause(s). As discussed above, the PNMT assessment for this individual was a series of notes and questions, as opposed to an analysis. The PNMT, working in conjunction with the IDT, had not completed the necessary analysis to identify the underlying cause(s) or etiology(ies) of her numerous falls.

c. For the applicable individuals, the Center did not submit ISPA's showing discharge discussions between the PNMT and IDT.

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

Summary: Since the last review, PNMP/Dining Plan implementation at San Antonio SSLC improved (i.e., Round 13 - 27%, and Round 14 - 53%). Based on observations, staff often completed transfers correctly. However, significant efforts continue to be needed to improve Dining Plan implementation, and positioning. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites or ate at an unsafe rate, staff not recognizing diet texture errors, staff not following positioning instructions) placed individuals at significant risk of harm. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. These indicators will continue in active oversight.

#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	53% 28/53

b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	63% 5/8
Comments: a. The Monitoring Team conducted 53 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 11 out of 23 observations (48%). Staff followed individuals' dining plans during 13 out of 25 mealtime observations (52%). Staff completed transfers correctly during four out of five observations (80%).		

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	357	134	347	247	331	352	36	370	178
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/1				0/1	N/A		N/A		
Comments: a. The Center did not submit data to show implementation of the plan the PNMT developed for Individual #247.											

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: For applicable individuals reviewed, IDTs had not developed and implemented clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services. These indicators will remain in active oversight.						Individuals:					
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/5	0/1	0/1	N/A	N/A	0/1	N/A	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/5	0/1	0/1			0/1			0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/5	0/1	0/1			0/1			0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/5	0/1	0/1			0/1			0/1	0/1

e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/5	0/1	0/1			0/1			0/1	0/1
<p>Comments: a. and b. Although Individual #347, Individual #247, Individual #352, and Individual #36 had deficits in OT/PT functioning, based on documentation reviewed as well as observation, an OT/PT goal/objective was not indicated. The remaining individuals had unmet OT/PT needs for which IDTs had not developed goals/objectives.</p> <p>c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. The Monitoring Team conducted full reviews for all nine individuals.</p> <p>In its comments on the draft report, the State disputed the findings for Individual #134, and stated: "These items should be N/A for Individual #134, since OT and PT gave rationale on why she is not receiving formal OT-PT services on Document TX-SA-1810-II.89..., page 8 of the assessment, second paragraph. Additionally, in the comment section, it is noted by the Monitor that an OT/PT goal/objective was not indicated for Individual #134." The Monitoring Team could not find anywhere in the draft report a statement that "an OT/PT goal/objective was not indicated for Individual #134." Moreover, although her assessment, which received a score of 0 for quality, indicated that she had functional motor skills, the assessors identified some lethargy potentially related to medications, and indicated that the IDT would discuss this concern during the ISP meeting. However, the OT/PT conducted no further assessment despite Individual #134 falling nine times between 4/1/18 and 10/15/18. As a result, it remained unclear whether or not she required formal OT/PT supports. The Monitor did not modify the original findings.</p>											

Outcome 4 – Individuals’ ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: These indicators will continue in active oversight.					Individuals:						
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	N/A									
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	N/A									
Comments: a. None.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Some individuals observed had equipment that did not appear to fit them properly. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, Indicator c will remain in active oversight. During											

future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for all of these indicators.											
[Note: due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]		Individuals:									
#	Indicator	Overall Score	258	176	23	331	110	239	281	228	32
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they 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.	71% 10/14	1/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		144	310	241	247	215				
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1	1/1	0/1				
Comments: c. The Monitoring Team conducted observations of 14 pieces of adaptive equipment. Based on observation of Individual #331, Individual #144, and Individual #215 in their wheelchairs, the outcome was that they were not positioned correctly. Individual #176's elbow splints did not appear to fit, and/or address the issue of skin integrity. 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, three indicators were in the category of requiring less oversight. At this review, no other indicators will be moved to this category.

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

In ISPs, without reliable useable data or without adequate implementation, it was impossible to determine progress. Action steps were not consistently implemented for any individuals.

Many SAPs contained most components. And, many SAPs were missing some of the same components. New SAP management at San Antonio SSLC may lead to continued improvement. It was good to see that SAPs were being implemented. Most SAPs were reviewed monthly, more so than ever before. It was also good to see that all SAPs were graphed, though more work is needed to make those graphs useful.

It was good to see that individuals were getting out into the community. Ensuring that 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 should be a target for the Center and the IDTs.

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

Since the last review, some good improvement occurred with the clinical relevance and measurability of communication goals/objectives the Monitoring Team reviewed. (The Center's performance with these indicators has varied over time.) It will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews.

It was good to see that often individuals' alternative and augmentative communication (AAC) devices were present and readily accessible. However, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Three goals had enough data to determine progress (two were met, one was progressing). The others were not making progress (based upon Center report) and for none were actions taken. 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	134	129	118	357	352	36			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	2/6	0/6	0/6	0/6	1/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/2	None met	None met	None met	None met	None met			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/4	0/6	0/6	0/6	0/5	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			
<p>Comments:</p> <p>4-7. For personal goals that did not meet criterion as described above, there was no basis for assessing progress in these areas.</p> <p>For the 10 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 for seven of the goals (i.e., indicator 3).</p> <p>For the three goals that did meet criteria with indicator 4, data indicated that two had been completed, but continued to be implemented without modification (for Individual #134). For Individual #352's greater independence goal, data indicated that he was making progress.</p> <p>See Outcome 7, Indicator 37, for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.</p>											

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.					Individuals:						
#	Indicator	Overall Score	134	129	118	357	352	36			
39	Staff exhibited a level of competence to ensure implementation of the	50%	0/1	0/1	0/1	1/1	1/1	1/1			

	ISP.	3/6										
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1	0/1			
<p>Comments:</p> <p>39. Direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs and very respectful and supportive to each individual in their interactions.</p> <p>The staff for three individuals were found to exhibit a level of competence to ensure implementation of the ISP. This included staff for Individual #357, Individual #352, and Individual #36. Staff 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. As noted throughout this section of the report, ISPs often included SOs that did not have specific implementation methodologies and this contributed to the lack of implementation.</p> <p>40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report.</p> <p>Going forward, IDTs need ensure all staff have instructions for carrying out action plans and then monitor the implementation of all action plans and address barriers to implementation.</p>												

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: It was good to see that SAPs were being implemented. About one-quarter that met criteria with the outcome 1 indicators also met criteria with indicator 6 (i.e., some SAPs did not have reliable data and/or were not meaningful). Even so, this showed improvement since the last review. Indicators 7 and 8 remained at about the same level of performance as at the last review. All three indicators will remain in active monitoring.					Individuals:							
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385	
6	The individual is progressing on his/her SAPs.	24% 6/25	1/3	1/3	0/2	1/3	0/3	2/3	0/3	1/3	0/2	
7	If the goal/objective was met, a new or updated goal/objective was introduced.	58% 7/12	2/2	2/3	1/1	N/A	1/1	0/2	N/A	1/2	0/1	
8	If the individual was not making progress, actions were taken.	0% 0/7	N/A	N/A	0/1	0/2	0/2	N/A	0/2	N/A	N/A	
9	(No longer scored)											
Comments:												

6. Overall, 61% of the SAPs demonstrated improvement based upon the Center’s own data. Many of those SAPs, however, were scored as 0 because the Center’s own data were not demonstrated as reliable (e.g., Individual #380’s brush his teeth SAP), or because the SAPs were judged not be practical or functional (Individual #375’s identify food items SAP).
7. Seven of 12 SAP objectives that were achieved were moved to the next step (e.g., Individual #139’s make choices SAP). This was good to see. Several other SAPs also achieved their objectives, however, they were continued without moving to the next step (e.g., Individual #385’s wash his clothes SAP).
8. None of the SAPs that were not progressing included actions to address the lack of progress (e.g., Individual #129’s activate his music SAP).

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

Summary: Many SAPs contained most components. And, many SAPs were missing some of the same components. New SAP management at San Antonio SSLC may lead to continued improvement. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals:								
			362	134	129	118	139	357	380	375	385
13	The individual’s SAPs are complete.	8% 2/25	0/3 24/30	0/3 25/30	0/2 18/20	0/3 24/30	0/3 25/30	1/3 25/30	0/3 24/30	1/3 26/30	0/2 18/20

Comments:

13. In order to be scored as complete, a skill acquisition plan (SAP) must contain 10 components necessary for optimal learning.

Because all 10 components are required for the SAP to be judged to be complete, the Monitor has provided a second calculation in the individual boxes above that shows the total number of components that were present for all of the SAPs chosen/available for review.

Although only Individual #357’s sign radio and Individual #375’s identify food items SAPs were judged to be complete, many of the SAPs contained the majority of the components. For example, 100% of the SAPs had a plan that included:

- a task analysis (when appropriate)
- behavioral objectives
- operational definitions of target behaviors
- relevant discriminative stimuli
- teaching schedule
- specific consequences for incorrect responses
- maintenance and generalization plans
- documentation methodology.

Regarding common missing components:

- 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 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 #362's count his money SAP). The instructions did not, however, indicate how staff should respond and score if an earlier mastered step now required prompting.
- 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 some SAPs (e.g., Individual #129's turn on his TV SAP where correct responses were to be followed by praise, and the opportunity to watch a preferred television program). Many SAPs, however, merely included saying "good job," which may not function as a potent reinforcer for every individual (e.g., Individual #380's brush his teeth SAP).

Outcome 5- SAPs are implemented with integrity.

Summary: San Antonio SSLC was conducting various integrity-related activities. This was good to see, however, direct observations by the Monitoring Team, however, showed a low level of correct implementation. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
14	SAPs are implemented as written.	20% 1/5	0/1	0/1	1/1	0/1	N/A	0/1	N/A	N/A	N/A
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	68% 17/25	2/3	3/3	0/2	3/3	2/3	2/3	1/3	3/3	1/2

Comments:

14. The Monitoring Team observed the implementation of five SAPs. Individual #129's activate his music SAP was judged to be implemented with integrity and scored accurately. Individual #118's make a snack SAP, Individual #362's put away his clothes SAP, Individual #134's identify numbers, and Individual #357's place towels in a jig SAP, however, were not implemented as written and/or scored accurately.

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 17 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 or did not achieve 80% levels.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: There was much improvement in performance for this outcome. That is, most SAPs were reviewed monthly, more so than ever before. It was also good to see that all SAPs were graphed, though more work is needed to make those graphs useful. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
16	There is evidence that SAPs are reviewed monthly.	80% 20/25	2/3	3/3	2/2	3/3	0/3	3/3	2/3	3/3	2/2
17	SAP outcomes are graphed.	40% 10/25	1/3	0/3	0/2	1/3	2/3	2/3	2/3	2/3	0/2
Comments: 16. This represents a dramatic improvement from the last review when 39% of SAPs were comprehensively reviewed each month. 17. All the SAPs were graphed. Many, however, were scored as 0 because they were generally not useful in displaying SAP progress because they did not reflect progression of steps (e.g., Individual #118's make a snack 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). Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	362	134	129	118	139	357	380	375	385
18	The individual is meaningfully engaged in residential and treatment sites.	67% 6/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found six to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations). 21. The facility's engagement data for September 2018 indicated that 78% of the residential and day treatment sites of the individuals											

in the review group achieved their goal level of engagement.

In addition, the Center reported on their upcoming plans to improve activities and engagement, called the “Active Treatment /ATS Plan of Improvement.” It included a variety of goals, indicators, and action regarding on campus activities, community integration, vocational assessment and employment supports, the music/memory program, and the seniors program.

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. Ensuring that 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 should be a target for the Center and the IDTs. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals:									
			362	134	129	118	139	357	380	375	385	
22	For the individual, goal frequencies of community recreational activities are established and achieved.	44% 4/9	0/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1	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	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	0/1

Comments:
22-24. San Antonio SSLC established individualized goals for the frequency of community outings and SAP training in the community. Individual #385, Individual #139, Individual #118, and Individual #134 achieved their community 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 applicable individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2						0/1			0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2						0/1			0/1
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2						0/1			0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2						0/1			0/1
Comments: a. through d. For the two individuals that had refused dental services, IDTs had not developed specific goals/objectives related to their 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: Since the last review, some good improvement occurred with the clinical relevance and measurability of communication goals/objectives the Monitoring Team reviewed. (The Center’s performance with these indicators has varied over time.) It will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant	67%	2/3	N/A	0/1	1/1	1/1	0/1	1/1	N/A	1/1

	and achievable to measure the efficacy of interventions.	6/9									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	67% 6/9	2/3		0/1	1/1	1/1	0/1	1/1		1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	13% 1/8	1/2		0/1	0/1	0/1	0/1	0/1		0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8	0/2		0/1	0/1	0/1	0/1	0/1		0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/8	0/2		0/1	0/1	0/1	0/1	0/1		0/1
<p>Comments: a. and b. Individual #134 and Individual #370 had functional communication skills. They were both part of the core group, so full reviews were conducted.</p> <p>The goals/objectives that were clinically relevant, as well as measurable were:</p> <ul style="list-style-type: none"> • Individual #357's signing for a radio goal, and her goal for imitating a word or sign. On 10/2/18, the second one was integrated into the ISP at an ISPA meeting, but at the time of the review, data were not yet due/available. She had another direct therapy goal to receptively identify a familiar item, but it was not included in her ISP/ISPAs. • Individual #247's goal to turn on the vibrating pillow with a switch. • Individual #331's goal to answer yes/no questions using his communication head switches. • Individual #36's goal to turn on music using a Big Mac switch. • Individual #178's goal to activate a device to say: "let's go for a walk." <p>c. through e. Although it was positive that a number of individuals had clinically relevant, measurable communication goals, unfortunately, QIDP integrated reviews most often did not include data to show implementation of the goals, months of data were missing, or data were included, but not analyzed (i.e., had the individual made progress, or did the team need to intervene?). For Individual #357's goal to sign for a radio, the QIDP included data in the monthly reviews, but even after months of refusals and/or no to limited progress, the IDT did not meet to review the goal and its implementation.</p>											

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: To move forward, QIDPs and SLPs should work together to make sure QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs. These indicators will remain in active oversight.					Individuals:						
#	Indicator	Overall Score	357	134	347	247	331	352	36	370	178
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/6	0/2	N/A	N/A	0/1	0/1	N/A	0/1	N/A	0/1

b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/3	0/1	N/A	N/A	N/A	N/A	0/2	N/A	N/A	N/A
<p>Comments: a. Unfortunately, QIDP integrated reviews did not include data to show implementation of many of the goals, months of data were missing, or problems with implementation were documented, but no action was taken.</p> <p>b. For Individual #357, it was unclear whether her IDT discontinued her direct therapy goal/objective.</p> <p>Individual #352's, IDT discontinued his calendar SAP and 20-icon AAC device without discussing next steps. With the calendar SAP, the IDT indicated he mastered it, but they did not identify an alternative goal, other than to say he would "communicate with a high tech augmentative table." In terminating his 20-icon AAC device, the IDT indicated he did not like it, because he would throw it. The IDT did not document a discussion of strategies to address his throwing of the device or the provision of direct interventions to potentially enhance its value to him.</p>											

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: It was good to see that often individuals' AAC devices were present and readily accessible. However, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.											
[Note: due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]					Individuals:						
#	Indicator	Overall Score	79	258	281	180	333	239	331	7	119
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	80% 12/15	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	40% 6/15	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1
			Individuals:								
#	Indicator		335	230	24	112	340	351			
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	0/1	0/1	1/1	1/1	1/1			
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		1/1	1/1	0/1	1/1	1/1	0/1			
c.	Staff working with the individual are able to describe and	90%									

	demonstrate the use of the device in relevant contexts and settings, and at relevant times.	9/10
Comments: a. and b. It was good to see that often individuals' AAC devices were present and readily accessible. However, frequently, when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.		

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

This Domain contains five outcomes and 20 underlying indicators. At the time of the last review, one indicator was in the category of requiring less oversight. Based on information the Center provided, between the time of the Monitoring Team’s last review and the Tier I document request, none of the individuals at San Antonio SSLC transitioned to the community, and no post-move monitoring occurred. As a result, the outcomes and indicators in Domain #5 were not scored.

Fifteen individuals, however, were in the active referral process.

A CLDP meeting was held during the onsite week for an individual who had been working towards transition for a number of years (Individual #304). This was great to see. Her transition activities included a lot of involvement from her IDT and her family. This was especially important given the individual’s history of behavioral and psychiatric presentation. Transition activities included ensuring establishment with a community psychiatrist, the completion of a detailed psychiatry transition assessment that included medication history, recent and current psychiatric status, and suggestions for support in the community. The CLDP meeting, however, was very long. Usually, there is a pre-CLDP meeting to handle a lot of the minutiae regarding the transition, so that it doesn’t need to be handled during the larger meeting.

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:			Individuals:								
#	Indicator	Overall Score									
1	The individual’s CLDP contains supports that are measurable.	N/A									
2	The supports are based upon the individual’s ISP, assessments, preferences, and needs.	N/A									
Comments:											

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary:			Individuals:								
#	Indicator	Overall Score									
3	Post-move monitoring was completed at required intervals: 7, 45, 90,	Due to the Center’s sustained performance, this indicator was moved to the category of requiring less oversight.									

	and quarterly for one year after the transition date											
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	N/A										
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.	N/A										
6	The PMM's assessment is correct based on the evidence.	N/A										
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	N/A										
8	Every problem was followed through to resolution.	N/A										
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A										
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A										
Comments:												

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary:											Individuals:	
#	Indicator	Overall Score										
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.	N/A										
Comments:												

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:											Individuals:	
#	Indicator	Overall Score										

12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	N/A										
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.	N/A										
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.	N/A										
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	N/A										
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	N/A										
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	N/A										
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.	N/A										
19	Pre-move supports were in place in the community settings on the day of the move.	N/A										
Comments:												

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary:					Individuals:							
#	Indicator	Overall Score										
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	N/A										
Comments:												

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
- In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- In the past six months, individuals with dental emergencies;
- Individuals with Do Not Resuscitate Orders, including qualifying condition; and
- In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
 - Crisis intervention restraints.
 - Medical restraints.
 - Protective devices.
 - Any injuries to individuals that occurred during restraint.
 - HHSC PI cases.
 - All serious injuries.
 - All injuries from individual-to-individual aggression.
 - All serious incidents other than ANE and serious injuries.
 - Non-serious Injury Investigations (NSIs).
 - Lists of individuals who:
 - Have a PBSP
 - Have a crisis intervention plan
 - Have had more than three restraints in a rolling 30 days
 - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
 - Were reviewed by 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.
 - QA/QI 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
- ISPA's, 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 ISPA's, 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 ISPA's 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
- ISPA's related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPA's
- 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

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

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

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