United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

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Background

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

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

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

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

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

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

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

Methodology

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

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

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.

Overall, a number of the individuals that the Monitoring Teams reviewed had experienced harm, and were at continued risk of harm. Interdisciplinary Teams (IDTs) had not conducted full assessments and analysis of information. As is illustrated in a number of outcomes within this report, significant gaps in good interdisciplinary coordination negatively impacted the IDTs' ability to address the individuals' needs. Center staff should engage in focused efforts to improve the care and treatment provided to individuals, particularly with regard to medical, nursing, and habilitation therapy supports, as well as the involvement of the entire interdisciplinary team to identify and address the underlying cause(s) of individuals' chronic conditions and risk factors.

Of particular concern, the quality of medical practitioners' assessment of and follow-up on chronic conditions, acute issues treated at the Center, as well as those requiring out-of-Center treatment did not meet generally accepted standards of care, and for some individuals reviewed, significant concerns were noted. For at least the past six reviews, the Center has shown poor compliance with these requirements. During this review, regression was noted even with requirements on which the Center had previously done well. In fact, due to declining conformance, the one indicator in less oversight related to communication between Center and hospital staff is in jeopardy of returning to active oversight. As indicated in previous reports, the Center needs to prioritize improvements in these areas. It is unclear to the Monitors why an emphasis has not been placed on improving medical care at the Center.

In addition to the above, the Monitors wish to comment on three topics/observations from the onsite week:

- Power outage: On Monday late afternoon of the review week, an electrical outage left the Center running on emergency back-up generators and no air conditioning. About an hour later, the Center activated its Incident Command System. This began with a meeting of about 20 management, clinical, and maintenance staff. The ADOA led the meeting. She led a discussion of how they would deal with various aspects of there being no/limited electricity, including the possibility of having to relocate individuals to the large activity building (which did have electricity and AC). The discussion was thorough and detailed. They talked about meals, medications, feeding pumps, refrigerators, staffing, evening activities for individuals, and relocating. For the possible relocation, they went home by home, and sometimes individual by individual. The ADOA kept the group focused, assigned specific responsibilities to the attendees, and made sure she got input from everyone present. Fortunately, the power was restored by about 11:00 pm and no one had to relocate.
- False allegations: One individual at the Center made nearly 2,000 allegations to DFPS intake over the past six months. This behavior had been occurring for many years, resulting in numerous staff being put in no contact status and causing the investigation system to spend a lot of time and resources on what turned out to be unfounded allegations. The Center, since the last review, put a plan into place that involved restricting his

access to the telephone while at the same time providing him with supervision to ensure his safety, and allowing him some access to the telephone. Overall, the Monitoring Team thought the approach and planning for this was done thoughtfully. The Center also obtained support and involvement from State Office in the development of the plan. The Center staff were meeting at least once per week to review its implementation and to make tweaks to the procedures.

- The Monitoring Team again notes the stability of much of the Center's management team and department director staff. This sets the stage for good progress to occur.

On an additional positive note, the Center showed sustained substantial compliance with the outcomes and indicators in psychology/ behavioral health. As a result, section K has now been exited from monitoring. The report below contains the current review period's performance scores and commentary.

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 62 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, 23 of these indicators were in the category of requiring less oversight. During this review two other indicators had sustained high performance scores and will be moved to the category of requiring less oversight. These were in restraints and quality assurance-ADRs.

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 generally low usage of crisis intervention restraint at the Center.

There was good management of restraint usage at the Center. This included thorough analysis of restraint data by the director of behavioral health services and the restraint reduction committee. For instance, supplemental monthly restraint frequency graphs were made that showed that the majority of restraints were for two of the individuals. This allowed for development of more focused interventions.

The restraint-related documentation was very good, well organized, and well administered. There were no pervasive or systemic issues.

If more than one medication is used during a crisis intervention chemical restraint, the rationale should be included in the psychiatrist's documentation/review of the incident.

Although more work is needed, some improvement was noted with regard to nurses completing assessments of individuals who required restraint. 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 in vital signs;

providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and following up on individuals' injuries.

Abuse, Neglect, and Incident Management

The IMC was relatively new and seemed to be well suited for the position given her strong background with APS and her eagerness to make improvements.

The 100% score for indicator 1 showed that the Center ensured proper staffing background checks and ANE training were done. Moreover, it showed that behavioral health, habilitation therapies, residential/day managers, and residential/day DSPs were attending to programs and plans.

Less than one-third of the investigations met criteria for correct reporting. Many were reported late, with little or no examination of the circumstances around this reporting.

Investigations contained all the essential elements (i.e., presence of elements, not quality of elements). The content of UIRs, however, needed substantial improvement. Most contained incomplete information, or information that should have been included had the Center been engaged in looking deeper when reviewing investigation reports.

The supervisory review process did not determine whether or not there were issues associated with investigations, such as with content, investigation timelines, and so forth, and then properly documenting these in the UIR. In all but one case, the Monitoring Team identified aspects of the investigation that were not identified (and not addressed) in the UIR.

Many HHSC PI investigations were not completed timely (this was a somewhat longstanding problem).

Investigations had recommendations when they should have and, for the most part, the Center took action and implemented those disciplinary and/or programmatic recommendations.

Other

IDTs discussed pretreatment sedation for most individuals, but they rarely covered all of the required topics. IDTs discussed whether action plans should be put in place; this was good to see. Sometimes these plans were put into place, but they weren't monitored for implementation of effect.

It was good to see that the Center completed clinically significant Drug Utilization Evaluations (DUEs). Given the Center's performance during this review and the last two reviews, the related indicator will move to the category requiring less oversight. The indicator related to follow-up on DUE recommendations will continue under active monitoring.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: San Antonio SSLC continued to do a good job in assessing and managing the overall usage of crisis intervention restraint as well as procedures to support completion of medical and dental procedures. These indicators remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
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.	82% 9/11	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (October 2018 through June 2019) were reviewed. Overall, the rate of restraint remained about the same as at the last review. When comparing census-adjusted with other Centers, San Antonio SSLC was in the middle, that is, six Centers had a higher rate and six Centers had a lower rate. The director of behavioral services continued to analyze the Center's data by looking deeper than only at the overall totals. For instance, similar to at the last review, the vast majority of crisis intervention restraints were due to two different individuals (not the same two individuals at the last review). Based on this, more focused interventions were developed and data were tracked for those two individuals and reported by the director. Thus, given that one of the goals of managing crisis intervention restraint usage is to work on reducing usage when possible, and to monitor implementation, this sub-indicator is scored positively.

The Center's restraint reduction committee remained active. The group reviewed restraints, restraint data, and implementation. The committee looked at the above 12 data sets. Minutes reflected good discussion.

The trend in usage of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint. The average duration of a crisis intervention restraint, however, remained the second highest in the state (after Lufkin SSLC). There was a large decrease in the usage of crisis intervention chemical restraint. During this review period, there were three usages; compared with 16 and 11 at the last two reviews. There were no usages of crisis intervention mechanical restraint.

Note: 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.

No individuals were using PMR-SIB (a continuation of good performance at the Center), and the number of individuals who had one or

more crisis intervention restraints each month remained about the same as at the last review at about seven. The Center reported no injuries to individuals as a result of implementation of crisis intervention restraint.

For assisting with completion of medical and dental procedures, non-chemical restraints and/or PTS were infrequently used. TIVA for dental procedures was being used based on availability of the procedure. There were no instances reported of any individual progressing from needing TIVA to being able to complete dental procedures with PTS or non-chemical restraints.

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. Two of the individuals reviewed by the Monitoring Team were subject to restraint. Restraints for two other individuals were also chosen for review. Of these four individuals, three received crisis intervention physical restraints (Individual #95, Individual #358, Individual #364), and one received crisis intervention chemical restraint (Individual #138). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for two of the four (Individual #95, Individual #358). The other seven 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. Indicator 9 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	358	138	364					
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.	100% 2/2	Not rated	Not rated	1/1	1/1					

10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	

Comments:
The Monitoring Team chose to review six restraint incidents that occurred for four different individuals (Individual #95, Individual #358, Individual #138, Individual #364). Of these, three 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.

9. When criterion for indicator 2 is met, this indicator is not scored. That was the case for two of the four individuals. For the other two individuals, all of the sub-indicators were met for both.

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: Due to sustained high performance for this review and the previous two reviews, indicator 13 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	95	358	138	364					
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	83% 5/6	1/2	2/2	1/1	1/1					
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A									

Comments:
13. For Individual #95 6/19/19, the IRIS form shows restraint was initiated at 3:30 pm and restraint monitor arrival was at 3:56 (i.e., at 26 minutes).

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.

Summary: Although more work is needed, some improvement was noted with regard to nurses completing assessments of individuals who had required restraint. 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 in vital signs; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and following up on individuals' injuries. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	95	358	138	364					
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	67% 4/6	2/2	1/2	0/1	1/1					
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	50% 3/6	2/2	1/2	0/1	0/1					
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/4	0/1	0/1	0/1	0/1					

Comments: The restraints reviewed included those for: Individual #95 on 4/30/19 at 3:50 p.m., and 6/19/19 at 3:30 p.m.; Individual #358 on 5/10/19 at 6:06 p.m., and 5/21/19 at 7:24 p.m.; Individual #138 on 4/2/19 at 1:27 p.m. (chemical); and Individual #364 on 6/13/19 at 9:40 a.m.

a. through c. For Individual #95 on 4/30/19 at 3:50 p.m., and 6/19/19 at 3:30 p.m.; and Individual #358 on 5/10/19 at 6:06 p.m.; nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects.

The following provide examples of problems noted:

- For Individual #95's restraint on 6/19/19, in an IPN, dated 6/19/19, at 5:04 p.m., a nurse noted that the individual had injuries from self-injurious behavior (SIB), including two open bites to her left arm, swelling to the right eye, and bleeding and swelling to her lips. The nurse noted the individual had no injuries from the restraint. Based on the IPNs submitted, it did not appear that the nurse developed and/or implemented a plan to address the injuries that resulted from the individual's SIB, including, for example, the potential head injury, treatment of her "open bites," and/or further assessments when the individual allowed for measurements of the injuries caused by her SIB.
- For Individual #358's two-person horizontal hold restraint on 5/21/19 at 7:24 p.m., no documentation was found of a skin

assessment. In addition, based on review of IView documentation, dated 5/21/19, at 7:35 p.m., the individual's respirations were high (i.e., 22). This entry was followed by another at 7:50 p.m., at which time the individual's respirations were 20, with an elevated pulse rate of 102. Center staff did not submit any additional IPNs, or IView entries to show that nurses followed up on the individual's elevated pulse rate.

- On 4/2/19, nursing staff administered two chemical restraints to Individual #138. They included intramuscular injections of Haldol, Ativan, and Benadryl. The nurse described the individual's mental status as "no change from baseline," which did not provide the specific information needed. In the IPN, the nurse documented the two sites for the administration of the chemical restraints. In IView entries, dated 4/2/19, at 3:33 p.m., 4:00 p.m., 5:00 p.m., and 7::55 p.m., nurses documented pulse rates that were high, and on 4/2/19, at 11:25 p.m., the individual had a low temperature (i.e., 97.5). Nurses did not follow applicable standards of care with regard to these abnormal vital signs. This was concerning, because the IM medications administered can cause orthostatic hypotension, and these medications in combination with medications he received as part of his oral medication regimen could have cumulative effects. Based on the documentation submitted, nursing staff did not provide instructions to the individual and/or staff related to observing and reporting potential side effects (e.g., for Benadryl and Haldol, potential side effects include difficulty urinating; for Ativan, potential side effects include a skin rash, or vomiting; and for Haldol, potential side effects include pain at injection site).
- On 6/13/19 at 9:40 a.m., staff used a five-minute, two-person arm neutralization restraint with Individual #364. However, based on documentation submitted, staff did not notify the nurse until 10:22 a.m. The nursing IPN stated: "DSP [direct support professional] came to nurse station at 10:22 am and reported [Individual #364], was placed in a arm neutralization restraint from 0940 until 0945 and is refusing to return back to dorm to be seen by the nurse." A nursing addendum IPN, dated 6/13/13, 12:33 p.m., indicated that the individual was back at the home, and the nurse conducted a post-restraint assessment. The individual refused the assessment three times, but the nurse did document the individual's respiratory rate. In this IPN, the nurse also documented: "no visible injury noted from restraint, no bruising, swelling noted to bilateral arms nurse not able to see bilateral knees at this time due to long short." The nurse did not document any follow-up related to the "swelling noted to bilateral arms."

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary:			Individuals:									
#	Indicator	Overall Score										
15	Restraint was documented in compliance with Appendix A.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary:			Individuals:									
#	Indicator	Overall Score										
16	For crisis intervention restraints, a thorough review of the crisis	Due to the Center's sustained performance, these indicators were moved to the										

	intervention restraint was conducted in compliance with state policy.	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: Psychiatry was involved as required in crisis intervention chemical restraint and follow-up. Multiple medications were used in this one case, without documented justification for why more than one medication was needed. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	138								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
48	Multiple medications were not used during chemical restraint.	0% 0/1	0/1								
49	Psychiatry follow-up occurred following chemical restraint.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 47-49. The above indicators applied to a chemical restraint episode regarding Individual #138. The psychiatrist completed the Administration of Chemical Restraint: Consult and Review form within the required timeframe. Three medications were utilized in the chemical restraint, Haldol, Ativan, and Benadryl. There was documentation of psychiatric clinical follow-up after the restraint episode as there was documentation that the psychiatrist participated in an ISPA regarding the chemical restraint two days after it occurred. There was also a quarterly psychiatric clinical encounter two days after the chemical restraint occurred. This was good to see.											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: The 100% score shows that the Center ensured proper staffing background checks and ANE training were done. Moreover, it shows that behavioral health, habilitation therapies, residential/day managers, and residential/day DSPs were attending to programs and plans. This indicator remains in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	95	16	358	142	347	362	321

1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 13/13 100% 3/3	2/2	2/2	2/2	1/1	2/2	1/1	1/1	1/1	1/1

Comments:
The Monitoring Team reviewed 13 investigations that occurred for nine individuals. Of these 13 investigations, 10 were HHSC PI investigations of abuse-neglect allegations (one confirmed, seven unconfirmed, one inconclusive, one referred for administrative review). The other three 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.

- Individual #7, UIR 19-315, HHSC PI 478562765, unconfirmed allegation of physical abuse, 12/18/18
- Individual #7, UIR 19-032, discovered fracture, finger, 1/14/19
- Individual #389, UIR 19-1016, HHSC PI 47739402, unconfirmed and inconclusive allegation of neglect, 4/29/19
- Individual #389, UIR 19-053, discovered laceration, chin, 4/29/19
- Individual #95, UIR 19-414, HHSC PI 47594817, unconfirmed allegation of physical abuse, 1/16/19
- Individual #95, UIR 19-481, HHSC PI 47610227, unconfirmed allegation of physical abuse, 1/28/19
- Individual #16, UIR 19-552, HHSC PI 47629175, unconfirmed allegation of neglect, 2/11/19
- Individual #358, UIR 19-266, administrative referral of allegation of neglect, 12/2/18
- Individual #358, UIR 19-590, HHSC PI 47641326, inconclusive allegation of neglect, 2/19/19
- Individual #142, UIR 19-318, HHSC PI 47564177, unconfirmed allegation of neglect, 12/19/18
- Individual #347, UIR 19-686, confirmed allegation of neglect, 3/8/19
- Individual #362, UIR 19-030, sexual incident, 1/7/19
- Individual #321, UIR 19-052, unauthorized departure and law enforcement encounter, 4/16/19

1. For all 13 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 10 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 the other three, the sub-indicators for trend reviews and implementation and review of plans were in place. These were primarily PBSPs and PNMPs.

There was one individual at San Antonio SSLC identified for streamlined investigations. He had a long history of making frequent

(2,000 in the six month review period) allegations, usually via telephone. There was appropriate documentation showing 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 it. In the last few months, a telephone restriction was put into place. Development of the plan involved behavioral health services, the QIDP department, State Office, and his entire IDT. The team was meeting each week to review the plan and its effects. Each week, some tweaks of the plan were required. Overall, this plan was developed and implemented thoughtfully with various protections put in place to reduce the likelihood of abuse/neglect even when access to the telephone was restricted.

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

Summary: Less than one-third of the investigations met criteria for correct reporting. Many were reported late, with little or no examination of the circumstances around this reporting. This is a decrease from past performance. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	7	389	95	16	358	142	347	362	321
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	31% 4/13	0/2	1/2	1/2	1/1	0/2	0/1	0/1	0/1	1/1

Comments:

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

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

- Individual #7 UIR 315: The incident occurred on 12/5/18 and was reported on 12/18/18. This late reporting was acknowledged and identified in the UIR.
- Individual #7 UIR 032: The UIR noted that this was coded as a serious injury at 9:04 pm and the facility director/designee was notified at 10:10 pm. This late reporting was property identified and noted in the UIR>
- Individual #389 UIR 1016: The HHSC PI report noted the incident occurring at 6:15 am and DFPS intake receiving the report at 3:15 pm. There was nothing in the UIR to explain this apparent late reporting.
- Individual #95 UIR 414: The HHSC PI report noted the incident to have occurred on 1/15/19 at 4:30 pm and reported on 1/16/19 at 5:24 pm. There was nothing in the UIR to explore or explain this late reporting.
- Individual #358 UIR 266: The HHSC PI report noted this incident to have occurred at 7:00 am and reported to DFPS intake at 7:15 am. The facility director/designee was not notified until 8:47 am. It appeared that the reported did not also notify the facility director/designee. Later in the report, an individual was identified as the possible reporter (the individual made frequent false allegations and was identified for streamlined investigations). This should have been included in the "who reported" tab in the documentation.

- Individual #358 UIR 590: The incident occurred at 3:33 pm and was reported at 5:13 pm. There was no information in the reported regarding who the reporter might be (i.e., staff, family, individual) or anything else about this late reporting.
- Individual #142 UIR 318: The HHSC PI report noted occurrence at 8:00 am and report to DFPS intake at 12:03 pm and to the facility director at 1:21 pm. The "who reported" tab in the documentation was blank and there was nothing else in the UIR explaining or exploring this late reporting.
- Individual #347 UIR 686: The incident occurred on 1/29/19 and was reported on 3/8/19. There was nothing to explain or explore this late reporting in the UIR.
- Individual #362 UIR 030: The incident occurred on 1/7/19 at 9:51 am and was reported to the facility at 4:40 pm and to DFPS intake at 6:10 pm. The UIR did not contain any further information about this late reporting.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.

Summary: Two of four staff interviewed incorrectly answered questions about reporting, one saying that reporters were allowed 24 hours to make a report and/or to whom a report should be made. This indicator (3) will remain in the category of requiring less oversight, but improvements need to occur for it to remain in this category after the next review.			Individuals:								
#	Indicator	Overall Score									
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting										
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: Three investigations did not meet criterion for immediate reassignment of alleged perpetrators because documentation did not provide enough detail. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	95	16	358	142	347	362	321
6	Following report of the incident the facility took immediate and	77%	1/2	1/2	2/2	0/1	2/2	1/1	1/1	1/1	1/1

	appropriate action to protect the individual.	10/13										

Comments:
For Individual #7 UIR 315, the alleged perpetrator was not identified until 12/27/18. The staff was then reassigned on 12/28/18 at 2:45 pm. The UIR did not address this non-immediate reassignment (e.g., the staff was not working at the time of allegation and reported to work as per schedule on 12/28/18).

For Individual #389 UIR 1016, the alleged perpetrator was reassigned at 10:00 pm. The UIR did not articulate what appeared to be a delay.

For Individual #16 UIR 552, the time of alleged perpetrator reassignment was not recorded in the UIR.

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: Indicator 9 will remain in the category of requiring less oversight, however, detail on one investigation that did not meet criteria is provided in the comments below. Problems with two investigations were identified regarding indicator 10. Indicator 10 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	7	389	95	16	358	142	347	362	321
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, these indicators were moved to the category of requiring less oversight.									
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.										
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)	85% 11/13	2/2	2/2	2/2	1/1	0/2	1/1	1/1	1/1	1/1
Comments: 9. Although in the category of requiring less oversight, two investigations did not meet criteria for this indicator:												

- Individual #358 UIR 590: A confirmation was overturned because of insufficient review and consideration of video recordings.

10. Three investigations did not meet criteria with this indicator:
    - For Individual #358 UIR 266, the findings and conclusions should have referenced the status of the two HHSC PI investigations referred to in the Administrative Referral. They were, per HHSC PI, directly relevant to this case. In reading this UIR, the reader would not be aware of the other two relevant investigations.
    - For Individual #358 UIR 590, the review of video evidence was flawed (see above).

Outcome 7– Investigations are conducted and reviewed as required.

Summary: This outcome points to two important areas for Center and IMC focus: completion of investigations in a timely manner, and thorough supervisory review of investigations to identify problems, such as late reporting or failure to examine all evidence. Investigation completion likely requires some work with HHSC PI. The Monitor's understanding is that there have been conversations between HHSC PI and State Office regarding the need for this to improve. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 7	389	95	16	358	142	347	362	321
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/QA specialist (unless a written extension documenting extraordinary circumstances was approved in writing).	62% 8/13	1/2	1/2	1/2	1/1	1/2	0/1	1/1	1/1	1/1
13	There was evidence that the supervisor/QA specialist had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	8% 1/13	0/2	0/2	0/2	0/1	0/2	0/1	0/1	0/1	1/1

Comments:

12. Many investigations had extensions that did not adequately justify the extension. Others started late and, therefore, were finished late. Overall, UIRS did not have the customary/typical entries at the end of the report showing dates for investigator completion, IMC sign-off date, and facility director sign-off.

In response to the draft version of this report, the State commented that the local San Antonio HHSC PI office experienced and continued to experience high workloads. The Director of HHSC PI was aware and involved in seeking a resolution.

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.

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.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.

Summary:			Individuals:								
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.										
Comments:											

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

Summary: It was good to see that investigations had recommendations when they should have and that, for the most part, the Center took action and implemented those disciplinary and/or programmatic recommendations. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	95	16	358	142	347	362	321
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 10/10	2/2	2/2	1/1	1/1	1/1		1/1	1/1	1/1
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	80% 4/5	1/2			1/1	1/1				1/1
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 7/7	1/1	2/2	1/1				1/1	1/1	1/1
Comments: 17. For Individual #95 UIR 315, there was no documentation to verify the recommended re-training of staff.											

There were three cases in which there was a confirmation of physical abuse category 2. In all three cases, the confirmed employee's employment was terminated.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists one facility indicator. It 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.	Monitoring of the Center's quality improvement program is now presented in the separate document "Monitoring Team Report for Quality Improvement Review."										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.											
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.											
23	Action plans were appropriately developed, implemented, and tracked to completion.											
Comments: 19. Two data sets were missing: individuals involved, and staff involved,												

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/5	0/1	0/1	0/1	0/1	N/A	N/A	N/A	0/1	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. Based on review of the documentation the Center submitted for these five instances of the use of TIVA, concerns with											

regard to proper procedures not having been followed included the following:

- None of the five individuals met criteria for the use of TIVA.
- Center medical staff did not complete a medical clearance assessment for Individual #7, Individual #346 or Individual #400.

The documentation indicated Center medical staff completed a medical clearance assessment, but it provided no evidence that an appropriate perioperative risk assessment was completed. The Center's policies with regard to criteria for the use of TIVA and general anesthesia as well as the policies related to perioperative assessment and management needed to be expanded and improved to address this concern. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Dental surgery is considered a low-risk procedure; however, the individual may have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation should also address perioperative management, which includes information on perioperative management of the individual's routine medications. A number of well-known organizations provide guidance on completion of perioperative evaluations for non-cardiac surgery.

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: It appeared Center staff provided incorrect information in response to the Monitor's document request. In the future, Center staff should provide the Monitors with the information as requested. This indicator will continue in active oversight.

#	Indicator	Overall Score	Individuals: 7	389	346	400	215	357	255	362	226
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									

Comments: a. Of note, as part of the Tier I document request, the Lead Monitors both asked for: "List of individuals who have had pretreatment sedation, with the following information (a) identify if PTS was for dental or medical, (b) what it was for (e.g., routine cleaning, hip surgery)…" In response to this request, the Center provided a list labeled: TX-SA-1908-III.12.t.medical. Both Individual #389, and Individual #362's names appeared on this list, but the procedures listed appeared to be dental procedures. As part of the Tier II document request, the Monitoring Team requested: "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," and "For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, documentation of committee or group discussion related to use of medication/anesthesia, Medical/Dental Restraint Checklist, as applicable, and operative note(s)." For both individuals, Center staff submitted statements saying the individuals did not receive pre-treatment sedation for medical procedures (but they had received TIVA for dental procedures).

Given these problems with the Tier I documentation, the Monitoring Team remains uncertain whether or not individuals at the Center

received pre-treatment sedation. Due to the inability to accurately select someone for review who met this criterion, it also remains unclear whether or not the Center's procedures and practices for administering pre-treatment sedation and monitoring the potential effects were sufficient to protect individuals from harm to the extent possible.

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: IDTs discussed pretreatment sedation for four of five individuals, but they rarely covered all of the required topics. IDTs for four of five individuals discussed whether action plans should be put in place; this was good to see. Sometimes these plans were put into place, but they weren't monitored for implementation of effect. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	20% 1/5	0/1	1/1	0/1	0/1			0/1		
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	1/1	1/1	1/1			0/1		
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.	67% 2/3		0/1	1/1	1/1					
4	Action plans were implemented.	50% 1/2			1/1	0/1					
5	If implemented, progress was monitored.	0% 0/1			0/1						
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1			0/1						

Comments:

1-6. This outcome and its indicators applied to Individual #7, Individual #389 Individual #95, Individual #68, and Individual #257.

1. Available ISPAs provided evidence that Individual #389's IDTs discussed behaviors observed during the procedure, other supports and interventions provided, additional supports or interventions that could be provided for future appointments, the risk-benefit of the procedure, and a determination of whether its use is considered restrictive or supportive. Additionally, there was documentation of

informed consent.

Available documentation for Individual #7, Individual #95, and Individual #257's ISPAs, however, did not document evidence of risk-benefit of TIVA, while Individual #95, Individual #68, and Individual #257's available ISPAs did not document a determination of whether TIVA was restrictive or supportive.

2. Individual #7's IDT determined that any actions to reduce the use of PTS/TIVA/GA would be counter-therapeutic. Individual #389, Individual #95, and Individual #68's IDT developed action plans to reduce the usage of TIVA. Individual #257's ISPA did not document a discussion of this issue.

3. Individual #95 and Individual #68's treatment strategies were based upon the hypothesized cause, in their ISPA, and written as a SO or SAP. Individual #389's treatment strategies were not written as a SAP, SO, or IHCP.

4. There was evidence that Individual #95's action plan was implemented, however, there was no evidence that Individual #68's treatment strategies were implemented.

5-6. There was no documentation of data reviews on progress of Individual #95's treatment strategies.

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	373	236	302	305	110	171			
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% 6/6	1/1	1/1	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% 0/6	0/1	0/1	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% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

	across disciplines that require improvement.										
e.	Recommendations are followed through to closure.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments: a. Since the last review, six individuals died. The Monitoring Team reviewed the six deaths. Causes of death were listed as:

- On 12/14/18, Individual #373 died at the age of 68 with causes of death listed as acute hypoxemic respiratory failure, and septic shock.
- On 1/30/19, Individual #236 died at the age of 56 with causes of death listed as aspiration pneumonia, and respiratory failure.
- On 1/31/19, Individual #302 died at the age of 63 with cause of death listed as anoxic brain injury.
- On 2/8/19 , Individual #305 died at the age of 65 with causes of death listed as septic shock, and aspiration pneumonia.
- On 2/19/19, Individual #110 died at the age of 59 with causes of death listed as septic shock, and pneumonia.
- On 6/1/19, Individual #171 died at the age of 62 with causes of death listed as acute respiratory failure, and aspiration pneumonia.

b. through d. Evidence was not submitted to show the Center staff conducted thorough reviews of the care and treatment provided to individuals, or an analysis of the mortality reviews to determine additional steps that should be incorporated into 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.

- Given that septic shock was listed as a cause of death for three of the six individuals who died, and pneumonia was listed as a cause for four of the deaths (i.e., three with aspiration pneumonia, and one with pneumonia unspecified), further inquiry into the assessment of, and supports, care, and treatment provided to these individuals was warranted. As is illustrated throughout this report, the Monitoring Team's review of medical, nursing, and habilitation therapy supports for other individuals the Center supports showed significant problems. The mortality reviews completed for the six individuals who died did not identify many of the systemic issues that the Monitoring Team identified (e.g., insufficient assessments, poor planning, incomplete follow-up for acute issues, and an overall lack of interdisciplinary coordination).
- It was good to see that nursing death reviews included a number of relevant recommendations, and that these often, but not always, were included in the administrative or clinical death reviews for follow-up.
- Overall, though, nursing death reviews, as well as other disciplines' death reviews did not provide an objective review of the assessment, planning, treatment, care, and supports that Center staff provided to the individuals who died. Center staff should use mortality reviews as an opportunity to identify potential areas in need of improvement, including issues that might have impacted the individuals' deaths, but also issues that impacted the overall quality of care the individual received during at least the last several months of their lives. The reviews conducted did not achieve this objective.
- At times, issues identified in either the clinical death reviews Center staff completed and/or that the external reviewer identified did not have follow-through in terms of recommendations in the clinical or administrative death reviews, and no justification was offered. For example:
    - For Individual #373, the external medical reviewer identified an issue related to the timely obtaining of labs prior to transfer. A recommendation was made for the medical staff to complete a in-service training on sepsis using an article from the medical literature with emphasis on having blood collected at the Emergency Department (ED) rather than on campus. It was not clear that this recommendation addressed the concern of the external reviewer.
    - For Individual #236, the external reviewer pointed out concerns related to the fact that an infectious disease (ID)

consultation could take up to six months to one year to obtain. There was no clear explanation as to why obtaining an ID consultation would be so difficult. There did not appear to be a recommendation to address this concern.

- For Individual #171, a recommendation was to discuss with families the risk-benefit of doing a colonoscopy versus a fecal immunochemical test (FIT) testing. However, the documentation provided no rational for this recommendation, nor did it fully explain how to assess individuals for the appropriateness of FIT testing. In addition, the dental review not signed by anyone, and given that no Dental Director was on staff, it was unclear who completed this portion of the review.

e. Some improvement was noted with regard to mortality committee writing recommendations in a way that ensured that Center practice improved. For example, a recommendation that read: "Nursing will be retrained on hypothermia guidelines" resulted in an in-service training, but the Administrative Death Review Committee also appropriately required monthly audits of any reported hypothermia events.

However, other recommendations did not follow this format. For example, another recommendation was for the Nursing Department to "develop and implement a guideline for nursing meal refusal assessment and documentation… evidence will be a copy of in-service." This did not ensure that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not nursing staff conducted assessments for individuals with two consecutive meal refusals.

The documentation the Center provided made it difficult to determine whether or not, and when a Clinical death review recommendation was considered closed. Specifically, the charts that listed the recommendations did not include a column to indicate the date on which the recommendation was initiated and a date on which it was closed, or to provide a "pending" status update.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: For the one potential ADR reviewed, staff reported it timely, and the Pharmacy and Therapeutics Committee discussed it. However, the PCP did not conduct necessary clinical follow-up.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	ADRs are reported immediately.	100% 1/1	1/1	N/A	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.	0% 0/1	0/1								
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 1/1	1/1								
d.	Reportable ADRs are sent to MedWatch.	N/A	N/A								
Comments: a. through d. On 6/5/19, Individual #7 experienced a seizure. The seizure was believed to be related to a drug interaction											

between fluvoxamine and carbamazepine that resulted in an increase in the carbamazepine level. While the ADR form documented that the PCP made a change in the dose of the carbamazepine, the records reviewed did not document that the PCP conduced any clinical assessment of the individual related to the seizure or the adverse drug reaction. On 6/26/19, the Pharmacy and Therapeutics Committee discussed the potential ADR.

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: Given that during the last two review periods and during this review, the Center completed clinically significant DUEs (Round 13 – 100%, Round 14 – 100%, and Round 15 – 100%), Indicator a will move to the category of requiring less oversight. Indicator b will remain in active monitoring.		
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 1/1

Comments: a. and b. In the six months prior to the review, San Antonio SSLC completed two DUEs, including:

- A DUE, dated 2/28/19, was completed to evaluate the proton pump inhibitor (PPI) duration of treatment and follow-up monitoring. A random sample of 20% of all active PPI orders was selected for review. Twelve individuals were reviewed. The DUE concluded that:
  - The proper dosage forms per diet texture were being selected; and
  - None of the individuals had baseline magnesium levels, and only half of the individuals had vitamin B12 levels since August 2016.

  Recommendations were made regarding:
  - Obtaining magnesium levels;
  - Selecting formulations of calcium;
  - Monitoring iron and thyroid stimulating hormone (TSH);
  - Initial selection of PPI; and
  - Reevaluation of PPI use.

  Follow-up was completed, including a follow-up DUE on 3/27/19; and
- An undated DUE was completed to evaluate Divalproex/Valproic Acid usage and laboratory monitoring. Forty-four individuals were identified, 37 of whom had active orders for valproic acid. From 2017 to 2019, a total of nine potential ADRs occurred involving eight individuals.

  Based on the results of the DUE, person-specific recommendations were generated. General recommendations included ensuring that standing orders for medication monitoring were written on all individuals treated with valproic acid and its derivatives, and continuing to use the Center's lab monitoring matrix, which required completion of a biannual comprehensive metabolic panel (CMP), complete blood count (CBC), and valproic acid level. 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, 30 of these indicators were in the category of requiring less oversight. For this review, no other indicators were moved to this category. The behavioral health/psychology indicators were moved to an exited status. Thus, there are now 19 indicators in the category of requiring less oversight and 13 indicators that have been exited.

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

All disciplines were submitting assessments in time for the IDT to review them prior to the annual ISP meeting.

Psychiatry CPE content and admission notes were scored higher than ever before. Annual psychiatry updates/evaluations were completed timely for all individuals, a nice improvement from previous reviews. The content was missing some components.

Annual behavioral health assessments and functional assessments continued to be consistently timely and complete.

In skill acquisition planning, was good to see that for the first time, all three assessments were current for all individuals. Inclusion of recommendations for skill acquisition in vocational assessments remained at about two-thirds.

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. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

Although the nine medical assessments reviewed included a number of the required components, Center staff should continue to improve their quality, as well as the quality of the interval medical assessments. Moving forward, the Medical Department should focus on ensuring annual medical assessments include as appropriate, family history, pertinent laboratory information, and plans of care for each active medical problem. In particular, without thorough plans of care, the assessments did not meet individuals' needs.

Overall, the quality and timeliness of dental assessments had improved. The Center should continue its focus on improving the quality of dental exams and summaries.

For seven out of nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments. Problems were noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments.

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, as well as thorough annual and quarterly physical assessments. It is essential in annual and quarterly record reviews that nurses provide specific dates. At times, individuals' clinical stories were unclear, because dates of various events or for summary data were missing. In addition, when individuals experience changes of status, nurses need to consistently complete assessments in accordance with current standards of practice.

In general, the PNMT documentation was clearly written, and thorough, and it was easy to follow the sequence of events in a succinct manner. However, often, individuals' needs necessitated the completion of comprehensive assessments, but the PNMT only completed a review without providing reasoned clinical justification. The PNMT also needs to improve the timeliness of assessments/reviews.

Since the last review, some improvement was noted with regard to the timeliness of Occupational/Physical Therapy (OT/PT) assessments. The quality of OT/PT assessments continues to be an area on which Center staff should focus. The new assessment template for OT/PT assessments from State Office was now in place and there is promise that this could improve the quality of the assessments. Of course, therapists need to utilize the corresponding guidelines to ensure that assessments are thorough and address individuals' strengths and needs.

Significant work continued to be needed to improve the quality of communication assessments and updates in order to ensure that Speech Language Pathologists (SLPs) provide IDTs with clear understandings of individuals' functional communication status; alternative and augmentative communication (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 is objectively evaluated.

<u>Individualized Support Plans</u>
Attendance was generally good at ISP meetings. QIDPs were familiar with supports needed by individuals and the status of those supports. Direct support staff were familiar with supports needed by individuals, their preferences, and risks that needed to be monitored.

There were some individualized meaningful goals for some individuals, but not yet enough for all individuals. Although ISPs generally included some goals based on preferences, none had action plans that supported achievement of those goals.

As noted in the past, employment opportunities were extremely limited and rarely individualized. Work opportunities were limited to the few contracts available at the workshop. There was no process in place to assess job skills and preferences outside of these few contracts.

Deeper discussions of living options and referral/transition obstacles was needed.

Action plans to address goals were very often implemented late or not at all, including many that were more related to staff actions (e.g., going to the park) than to more complicated teaching SAPs.

In psychiatry, the Center maintained stability in its psychiatric provider staff. This was good to see.

The psychiatrists made progress in identifying psychiatric indicators and psychiatric goals. For the most part, they solely used the behavioral health PBSP target behaviors as psychiatric indicators. Identifying indicators that more specifically relate to the diagnosis is a next step for them.

In behavioral health services, overall, the department continued to meet most of the criteria for the outcomes and indicators assessed by the Monitoring Team. The BHS department included 10 BCBAs.

The PBSP was complete, meeting all requirements for content and quality.

In behavioral health, regarding the collection and assurance of reliable PBSP data, San Antonio SSLC scored 100% on this for the first time (that is, the first 100% score for any SSLC for this indicator), an improvement from 75% at the last review. It was good to see this important foundational aspect of behavioral programming and treatment being now a regular part of the BHS/PBSP program.

For SAPs, although all individuals had one or more SAPs, most individuals could have benefited from additional SAPs. To that end, the Center was working on improving the way IDTs generated ideas for topics/skills for SAPs. The QIDP Coordinator, the SAP manager, and the ADOP were working together on this project.

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.

Although more work is needed, since the last review, some continued improvement occurred with regard to IDTs defining in IHCPs the frequency of interval medical reviews, and basing their decisions on the individuals' levels of risk and related guidelines. As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.

Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' physical and nutritional management (PNM) needs. It was concerning that for some individuals with PNM-related needs/risks, current IHCPs to address their needs were not available/submitted. Often, IHCPs did not include specific PNM interventions, or included general statements such as "implement PNMP" without details about the interventions staff needed to implement. Significant improvement is needed with regard to improving the quality of the PNM components of the IHCPs.

On a positive note, some improvement was noted with regard to the quality of the Physical and Nutritional Management Plans (PNMPs). With minimal effort and attention to detail, the Habilitation Therapy Department staff should be able to continue to make the needed corrections, and by the time of the next review, the Center could make additional progress on complying with this requirement.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: There were some individualized meaningful goals for some individuals, but not yet enough for all individuals. Some goals were written in measurable terminology and some were not. Actions to meet goals were not implemented for most goals and for those for which there was some implementation, there were little data that were reliable. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	16	390	362	226			
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	1/6	2/6	4/6	3/6	2/6	1/6			
2	The personal goals are measurable.	0% 0/6	3/6 0/1	2/6 1/2	3/6 3/4	2/6 2/3	2/6 2/2	1/6 0/1			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			
Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #389, Individual #7, Individual #390, Individual #16, Individual #362, and Individual #226. The Monitoring Team reviewed in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings at San Antonio											

SSLC.

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.

Thirteen personal goals met criterion as aspirational statements of outcomes, based on an expectation that individuals will learn new skills and have opportunities to try new things that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live.

Below is detail regarding the different categories of personal goals:

- Leisure goals for three individuals met criteria. These were:
    - Individual #389's goal to attend four different food festivals in a year.
    - Individual #390's goal to attend four concerts/festivals of her choosing.
    - Individual #16's goal to attend the SA FIRE program.
- Leisure goals that did not meet criteria were:
    - Individual #7's goal to feed the animals at a drive through safari was a one-time event that was unlikely to lead towards developing new leisure skills or interests.
    - Individual #362's goal to attend the Los Magnificos Car Show was also a one-time event that might be a good action plan to a broader goal, but was not aspirational for developing new leisure skills.
    - Individual #226's goal to attend the annual Fiesta de la Flor festival by 2022 was also a one-time event that should not take three years to accomplish.

- Two relationship goal met criteria:
    - Individual #389's goal to visit his father monthly.
    - Individual #226's goal to attend facility organized Selena activities once per quarter would expand her opportunities to participate with peers outside of her home engaged in activities of interest since she spent very little time outside of her home.
- These relationship goals did not meet criteria:
    - Individual #7 did not have a relationship goal.
    - Individual #390's goal to care for pet fish was unlikely to lead towards building new relationships or relationship skills.
    - Individual #16's goal to host a campus Olympic event was not well defined. Since he has goals to live and work in the community, the IDT needs to consider goals that will strengthen/build relationships in the community.
    - Individual #362's goal to invite a friend along on an activity was not aspirational. His ISP indicated that he routinely interacted with peers at the facility and had good communication skills

- Work/School/Day goal for three individuals met criteria.
    - Individual #390's goal to graduate from high school.
    - Individual #16's goal to work part-time as a tour guide for new hires at the facility.
    - Individual #362's goal to work part-time at a car wash.
- These work/school/day goals did not meet criterion:
    - Individual #389's work goal to sign when he was done with work was a compliance based goal. Based on his work refusals and history of not staying on task, the team had not adequately assessed his work preferences.
    - Similarly, Individual #7's goal to complete a unit of work was based on compliance with working on a task that she had clearly shown little interest in doing. She also needed a work assessment that explores her preferences.
    - Individual #226 did not have a work/day goal.

- Two of six individuals had a greater independence goal that met criteria. These were:
    - Individual #7's goal to make her own snack.
    - Individual #16's goal to complete courses through a higher education program.
- These greater independence goals did not meet criterion.
    - Individual #389's goal to select his favorite TV program to watch. Staff reported that Individual #389 had not shown interest in watching TV.
    - Individual #390's goal to make a dish for open house by 2020 was not a long term aspirational goal for her.
    - Individual #362's goal to two step with a partner at a festival was unlikely to lead towards greater independence.
    - Individual #226 did not have a greater independence goal.

- Living options goals for Individual #390, Individual #16, and Individual #362 were aspirational goals to move into the community.
    - Individual #389, Individual #7, and Individual #226 had goals to remain where they were currently living. These goals were not aspirational, as they had already been achieved.

2. In order to meet criterion for measurability, personal goals must be measurable in a stand-alone manner, that is, a review of the ISP and action plans is not needed to make this determination. The outcome of the goal must be observable and measurable, and the goal must be specific, clearly defining the conditions under which the goal would be achieved. Vague terminology, such as participation, does not describe actions on the part of the individual working toward goal-achievement.

Of the 13 personal goals that met criterion for indicator 1, eight met criterion for measurability. The following goals were not measurable as written, so that all staff could determine when the goal had been accomplished:

- Individual #389's goal to attend food festivals.
- Individual #7's goal to make her own snack.
- Individual #390's goals to attend concerts.
- Individual #16's goal to complete preferred classes.
- Individual #226's goal to attend Selena events.

Some goals did not meet criteria for Indicator 1, however, as written, they were measurable. These were these five goals:

- Individual #389's goal to continue living at San Antonio SSLC.
- Individual #7's goal to feed animals at the drive through safari, her goal to complete one unit of work per work session, and her goal to continue living in her current home.
- Individual #226's goal to continue living in her home.

The Monitor has provided two calculations in each individual's scoring box above. One is for the total of six that were written in measurable terminology and the other is only for those that were scored positively for indicator 1.

3. None of the goals that met criteria for both indicator 1 and 2 had reliable data to determine if the individual was making progress. QIDP monthly reviews and SAP data sheets indicated that a majority of the action plans were never implemented (also see indicator 4 under domain 4 of this report). For those that were implemented, consistent data were often not available to determine progress towards goals. In most cases, service objectives lacked specific staff instructions for implementation, thus, staff lacked guidance needed to implement action plans.

Some examples where data were not reliable and/or available were:

- For Individual #16's goal to attend SA Fire, the QIDP included email correspondence to get him enrolled in the program. It's not clear when his application was approved or when he began attending the program. Data regarding program attendance was not found. Similarly, the QIDP monthly review documented correspondence regarding his work goal, however, there were no data regarding implementation or progress. The QIDP indicated that there was no documentation related to his QIDP monthly reviews indicated that data could not be found related to his work goal to sign "done" when he completed his work.
- For Individual #390's goal to make a dish for an open house, the QIDP monthly review indicated that the related action plan was revised in April 2019. This were no other data related to this action plan. It's not clear what progress she has made towards this goal.
- QIDP monthly reviews for Individual #226 indicated that her recreation goal to attend a festival and her relationship goal to attend Selena events at the facility had not been implemented as of June 2019.

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 reliable 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.

The annual ISP meeting for Individual #16 was observed. Planning was somewhat fragmented. The IDT had not established a clear vision for what Individual #16 wanted to do in the next few years and what skills and supports he would need to achieve his vision. For example, his work goal from the previous year had never been implemented, so the team agreed to discontinue that goal and let him try working on the laundry pick up service crew. This job was chosen based on what jobs were open at the facility rather than an assessment of Individual #16's interests or skills that he might want to develop to work in the community someday. He agreed that he wanted to try the job, however, it was the sole work option presented to him. The team agreed not to refer him for placement in the community in part due to his behavior, however, all assessments indicated that he could live in the community and all team members

recommended referral. His team all agreed that his behavior was stable. The team seemed more focused on filling in all the blanks in the ISP document with something rather than taking a comprehensive look at what he wanted for the future and developing a good plan to help him achieve his goals.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: Scores remained about the same as at the last review. As the quality of personal goals improve (indicators 1 and 2), it is likely that this set of indicators will also improve. Even so, the Monitor recommends that the Center use each of these indicators to assess the individual's ISP. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	16	390	362	226			
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	0/6	1/6	0/6	1/6	1/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	67% 4/6	0/1	0/1	1/1	1/1	1/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	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.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
14	ISP action plans integrated encouragement of community participation and integration.	50% 3/6	0/1	0/1	1/1	1/1	1/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to	0%	0/1	0/1	0/1	0/1	0/1	0/1			

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

Comments:

8. Thirteen 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 (i.e., for this indicator 8). 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.

Four of 13 goals had action plans that supported the achievement of those goals. These were:

- Individual #7's greater independence goal.
- Individual #16's recreation goal.
- Individual #362's work/day goal.
- Individual #226's relationship goal.

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. Many action plans stated what staff would do, but not what action the individual would take to show progress towards accomplishing his or her goal, thus, data would indicate how many times staff had implemented the plan instead of measuring specific progress towards the goal. IDTs still needed to focus on laying out a clear path of assertive action plans to meet each goal.

Examples of goals that did not have action plans that would lead to achievement of the goal included:

- Individual #16 had a goal to take courses through a higher education program in the community. He had one related action plan to inform the QIDP of what classes he would like to take. Action plans were not developed to assist him with this process or support him to enroll in the classes that he identified.
- Individual #389 had a goal to select his favorite television program to watch. He had one related action plan for a SAP to teach him to sign "watch" when he wanted to watch TV. There were no action plans to support him to choose a program to watch.
- Individual #390 had a goal to graduate from high school. There were two related action plans to enroll in High School and to go shopping for school clothes and school supplies. Her IEP goals should have been integrated into her ISP.

9. One of the ISPs had action plans that integrated preferences and opportunities for choice. For the most part, goals and action plans were based on individual preferences, however, opportunities for making choices were limited. Action plans ensuring opportunities for work and day programming based on preferences and supported by exposure to new activities were particularly limited. Individual #362's ISP did offer opportunities to make choices through choosing events that he would attend and making purchases.

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. 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 not included in action plans for individuals in any substantial way.

Self-advocacy committee, peer support specialists, and other supports from the human rights department might be incorporated into individuals' ISPs related to decision-making. These activities were occurring on campus and the human rights officer was actively involved with the committee and with many individuals.

11. Four of the ISPs met criterion for this indicator to support the individual's overall independence. Examples of ISPs that included action plans to promote greater independence in a meaningful way were:

- Individual #390 had action plans to learn to cook, shop for school supplies and fish supplies, and make a shopping list.
- Individual #16's attendance at the SA FIRE Program, taking college courses, paying for purchases, and completing his oral care were all likely to increase his independence.
- Individual #362's action plans to purchase his ticket to the car show, work on the ground crew, apply for a job at a car wash, purchase clothing, and complete oral care were likely to lead towards greater independence if implemented.
- Individual #226's action plan to learn to use a switch would increase her independence.

12. None of the ISPs integrated strategies to minimize risks in ISP action plans in a meaningful way. While risks were addressed through action plans included in the IHCP, supports were not routinely 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. Indicator 13 includes examples of supports that ancillary disciplines had recommended to address risk areas that were not integrated into the ISP.

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. While IDTs were attempting to integrate behavioral objectives into action plans to support goals, for the most part, they became stand alone action plans and were not truly integrated into action plans for functional skill building. For example,

- Individual #389's ISP did not integrate strategies to address his pica and SIB diagnosis.
- Individual #7's ISP did not include strategies to address her refusal to complete preventative medical exams. There was no evidence that the IDT had included all needed disciplines in developing supports to address her ongoing falls. It did not appear that current supports were effective and she remained at risk for injuries during falls.
- Individual #390's behavioral supports were listed as stand alone action plans, but not integrated into supports for school or outings into the community.
- Behavioral support goals were integrated into living option action plans for Individual #16. They were not integrated into other action plans.
- Individual #226's plan did incorporate her SLP's recommendation to use a switch to control her environment. Her goal to attend the sensory program did include action plans to address positioning recommendations during activities.

ISPs summarized assessment results, however, assessments offered few recommendations for supporting new skill development. When there were recommendations, they were rarely integrated into action plans for learning new skills. This was particularly true for communication skills.

14. Three of the ISPs included action plans to support meaningful integration into the community.
    - Individual #390 had action plans related to her going to school in the community.
    - Individual #16 was attending a community recreation program that was a good opportunity for integration. He also had action plans to live and work in the community.
    - Individual #362 also had action plans to live and work in the community.

Although individuals had goals to live and work in the community, action plans minimally supported community integration. 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 movies, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. Two of the ISPs documented the IDT's consideration of opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Comments for all six individuals are below:
    - Individual #390 attended public school.
    - Individual #362 had a goal to work part-time in the community at a car wash. In the meantime, he worked part-time on a ground's crew.
    - Both Individual #389 and Individual #7 often refused to work at the sheltered workshop. Both ISPs acknowledged their lack of interest in current programming. Little had been done to explore work opportunities outside of their current assigned areas. Work/day action plans focused on compliance with staying on the job rather than skill development or job exploration.
    - Individual #16 attended a community recreation program three days per week in an integrated setting. This was good to see, however, his IDT had not considered exploring job opportunities and preferences that might lead towards him working in a more integrated setting. His ISP noted that he was not interested in jobs available at the facility and that sensory and other day programs at the facility were not appropriate for him. His annual ISP meeting for the upcoming year was observed. The IDT agreed to let him try to minimum wage job picking up laundry at the facility. While this was a step in the right direction, the decision was not based on an adequate vocational assessment to determine his preferences or needed job skills. At age 27, supporting Individual #16 to gain work skills that might lead towards meaningful employment should be a priority.
    - Individual #226 attended day programming at her home. She rarely had opportunities to leave her home.

Overall, action plans did not address preferences in regard to work/day programming. Action plans were not present that would support skill development which might lead to work/day programming in a less restricted setting. Vocational assessments were not adequate for identifying preferences outside of the limited vocational opportunities offered at the facility and assessing skills that might lead towards work in a more integrated setting.

16. One ISP supported 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. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests, then build on skills related to those preferences. There was a significant lack to vocational training offered by the facility and few individuals had opportunities to work in interesting jobs that paid fair wages.

- Individual #390 attended public school which would provide substantial opportunities for functional engagement and skill building.
- As noted in indicator 37, day programming for other individuals was not based on assessments that identified skills needed to more independently participate in meaningful activities during the day. Action plans generally stated what activity the individual would be engaged in during the day, but did not identify specific training and supports that would be needed to teach new skills.

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 had not been implemented, or the individual failed to make progress, were continued from the previous ISP without addressing barriers or were just deleted. None of the ISPs addressed identified barriers to community transition in a meaningful way.

18. One of the goals had a set of action plans with enough detail to ensure consistent implementation, data collection, and review. 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. When skill acquisition plans were developed, they also were not adequate for providing staff with guidance to implement plans.

- The IDT had developed a SAP related to Individual #7's goal to prepare a snack independently that met criteria for this indicator.

Although IDTs had created some 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 Center needs to focus on barriers that are preventing individuals from achieving their goals and develop action plans to address those barriers.

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

Summary: Performance on this section and content of the ISP remained about the same as at the last review. Indicator 21 was the one indicator that showed improvement. Deeper discussions of living options and referral/transition obstacles was needed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	16	390	362	226			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT	50% 3/6	0/1	0/1	1/1	1/1	1/1	0/1			

	(e.g., communication style, responsiveness to educational activities).										
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1			0/1						
21	The ISP included the opinions and recommendation of the IDT's staff members.	83% 5/6	1/1	1/1	0/1	1/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	Due to the Center's sustained performance this indicator was moved to the category of requiring less oversight.									
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	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% 0/1			0/1						
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1			0/1						
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A									

Comments:

19. Three ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT. For Individual #389, Individual #7, and Individual #226, the ISP did not document discussion by staff of their known living option preferences (i.e., environmental preferences).

20. Individual #16's ISP was observed. The IDT did not discuss a range of options available in the community that might support Individual #16's preferences regarding his living options.

21. Five of the ISPs included the opinions and recommendations of staff members, along with a summary statement of those recommendations.

- Individual #16's ISP did not include a clear rationale for the IDT decision not to refer him to the community. The rationale

stated that his needs would not be readily met in the community due to the need for extra staffing considerations throughout the day.

22. Five of the ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. Individual #226's ISP noted that her LAR could not be reached for input, however, she was present at the meeting. Her wishes were not documented.

23. One of the individuals (Individual #390) had a thorough examination of living options based upon their preferences, needs, and strengths. The other five ISPs did not indicate that the IDT had considered other living options that specifically supported their preferences and support needs.

24. Five ISPs identified a list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #16's ISP did not clearly identify which supports were not available in the community.

25. Individual #16's ISP was observed. The QIDP reported that all assessments recommended community referral. She then asked the team present to state their opinion. Individual team members stated vague barriers to referral (his level of supervision, his behavior) and agreed not to make a referral. Earlier in the meeting, team members stated that his behavior was stable. The IDT did not identify specific supports that could not be provided in the community.

26. None of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified.

27. Individual #16's IDT did not develop action plans to specifically address identified obstacles to referral at his annual IDT meeting. Obstacles were not clearly defined.

28. 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. ISPs included action plans for the individual to attend a provider fair and group home tours, however, these were not individualized based on the individual or LAR's current knowledge regarding living options or specific to living options that could provide identified supports needed in the community.

29. Barriers were identified to referral for all individuals.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISP action plans to address goals were very often implemented late or not at all, including many that were more related to staff actions (e.g., going to the park) than to more complicated teaching SAPs. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	7	389	16	390	362	226			

		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).	50% 3/6	0/1	1/1	1/1	0/1	1/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			

Comments:

32. Documentation was not submitted that showed that all action plans were implemented within a timely basis for any of the individuals. Some examples of action plans that were not implemented within 30 days of development were:

- For Individual #389, his QIDP monthly review and SAP data collection sheets indicated that his action plan for his work goal was not implemented in May or June 2019. His action plans should have been implemented by 5/9/19. As of July 2019, he had not attended a food festival (his recreation goal).
- Individual #7's ISP action plans should have been implemented by January 2019. There were no implementation data showing that Individual #7 had been to the park to feed the ducks as of July 2019.
- Individual #390's action plans should have been implemented by February 2019. Her application for Special Olympics was not submitted until June 2019. She had not visited a pet store to shop for fish as of July 2019. She did not begin going to cooking classes until June 2019.
- Individual #16's ISP should have been implemented by September 2018. His QIDP monthly reviews indicated that action plans related to his relationship and independence goals were never implemented.
- Individual #362's QIDP monthly reviews indicated that action plans related to his relationship and independence goal had not been implemented.
- Individual #226's ISP should have been implemented by March 2019. QIDP monthly reviews indicated that action plans to support her recreation, relationship, and living option goals were not implemented as of July 2019.

33. Three of six individuals attended their ISP meetings (Individual #16, Individual #362, Individual #389)

34. One of the individuals had an appropriately constituted IDT based on the individual's strengths, needs, and preferences, who participated in the planning process (Individual #390). Although for the most part, team participation was good, psychiatry was not present at four of the IDT meetings where their input would have been essential in developing supports. Individual #226 had significant medical and OT/PT support needs. Neither were present at her meeting.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: It was positive to see that assessments were generally completed and submitted to the IDT in a timely manner. Assessments, however, rarely included sufficient recommendations to guide the team in developing supports. With sustained high performance indicator 35 might be moved to the category of requiring less oversight after the next review. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	16	390	362	226			
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.	80% 4/5	1/1	1/1	0/1		1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			

Comments:

35. Four of five 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.
    - Individual #16's IDT did not consider the need for a vocational assessment to determine his work preferences. His current ISP noted that he had no interest in jobs available at the facility. His work goal to work as a tour guide for new staff was never implemented, then revised to pick up laundry at the facility for the upcoming year. The team agreed to both goals without assessing him to determine what skills were needed for either job or what job interests he might have.

36. Five of the IDTs arranged for and obtained all needed, relevant assessments prior to the IDT meeting.
    - Individual #389's vocational assessment did not include recommendations related to developing a work goal for him and his OT/PT assessment did not include recommendation to address is risk for falls.

It was positive to see that assessments were generally completed and submitted to the IDT in a timely manner. Assessments rarely included sufficient recommendations to guide the team in developing supports. Without relevant recommendations for the IDT to review, comprehensive supports and services were not developed, and all risks were not addressed.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: IDTs met regularly, which was good to see, but rarely revised goals, action plans, or supports. Implementation was poor and data rarely collected, additionally hampering the QIDP and IDT's ability to review and revise plans. Lack of implementation, however, should be directly addressed by the Center. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	7	389	16	390	362	226			

		Score									
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. The IDTs routinely met to review supports, services, and serious incidents during ISPA meetings. IDTs did not routinely revise supports or goals or address barriers when progress was not evident. As noted throughout this report, data were not available to support consistent implementation. Without adequate data, IDTs were unable to make decisions regarding progress or lack of progress towards goals.

- For all individuals, action plans to support one or more goals were never implemented months into the ISP year.
- There was rarely documentation to support aggressive action by the IDT to address lack of implementation.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals.

For the most part, monthly reviews were completed and included a cursory review of all services. They included little meaningful information regarding progress towards goals and efficacy of supports.

Some QIDP monthly reviews included data for some action plans, but rarely included 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 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 and, as needed, revise the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:							
#	Indicator	Overall	7	389	346	400	215	357	255	362	226

		Score									
a.	The individual's risk rating is accurate.	11% 2/18	0/2	0/2	0/2	1/2	1/2	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.	44% 8/18	1/2	0/2	1/2	2/2	0/2	1/2	2/2	0/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #7 – seizures, and constipation/bowel obstruction; Individual #389 – respiratory compromise, and falls; Individual #346 – diabetes, and fractures; Individual #400 – dental, and gastrointestinal (GI) problems; Individual #215 – respiratory compromise, and constipation/bowel obstruction; Individual #357 – skin integrity, and falls; Individual #255 – GI problems, and aspiration; Individual #362 – choking, and cardiac disease; and Individual #226 – infections, and weight].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #400 – dental, and Individual #215 – respiratory compromise.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The exceptions were for Individual #255 – GI problems, and aspiration, for whom the IDT developed change-of-status IRRFs. The following individuals did not have changes of status in the specified risk areas: Individual #7 – constipation/bowel obstruction; Individual #346 – diabetes; Individual #400 – dental, and GI problems; Individual #357 – skin integrity; and Individual #226 – weight.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: At San Antonio SSLC, there was progress in the sub-indicators for some of the indicators in this outcome. The psychiatry department was identifying indicators for reduction that were consistently identified, consistent with the individual's diagnosis, and in some cases, were described as related to a specific individual. The next step is for psychiatry to establish goals related to the identified indicators. Regarding indicators for increase (i.e., positive/desirable behaviors that indicate the individual's condition, or ability to manage the condition is improving), these indicators were not yet identified for the individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142

4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	1/2	1/2	0/2	0/2	0/2	1/2	1/2	0/2	1/2
5	The individual has goals related to psychiatric status.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	1/2	1/2	1/2	1/2	1/2	1/2	1/2	0/2	1/2

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

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 an individual's 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. In psychiatry, the focus is upon what have come to be called psychiatric indicators.

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 and normed for this population.

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.

San Antonio SSLC showed progress in this area as five individuals in the review group had one or more indicators related to the reduction of psychiatric symptoms (sub-indicator a). The indicators were described in observable terminology and, therefore, it was possible to determine how the indicators related to the individual's psychiatric diagnosis or diagnoses (which they were) and how they should be identified for an individual. (sub-indicator b). In four examples, regarding Individual #95, Individual #68, Individual #16, and Individual #390, however, the indicator for decrease was not specifically defined in observable terminology so that it could be identified for tracking (sub-indicator c).

None of the individuals had an indicator for increase identified.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for five individuals in the review group and for none of the individuals for psychiatric indicators for increase.

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, none of the individuals had acceptable goals written regarding psychiatric indicators for reduction (sub-indicator a). In most of the examples, the indicator for reduction was the same as the behavioral health target behavior; however, the specific goal was not included in the psychiatric documentation. In order to meet the criteria in this section, there is a need to identify both the goals and how data will be collected (sub-indicator b). As most indicators for reduction were identical to the behavioral health target behavior, it could be assumed that this would be gathered via the PBSP, but this was not specifically documented. As there were no indicators for increase identified, there were no goals established for those.

To reiterate, there were no psychiatry goals established for either indicators for reduction or increase, and no notations indicating the method of data collection. Data would likely be collected via direct care staff or behavioral health services and while this seems reasonable, the indicators will need to be clearly described in observable terminology in order for them to be accurately identified.

Further because the purpose of the psychiatric indicator is to identify and then determine an individual's symptom experience, a mixture of individually defined indicators and/or data from direct observations by staff of psychiatric indicators with goals and the collection of data utilizing rating scales normed for this population could be considered for some individuals. Currently, the facility psychiatrists were not identifying rating scales for use in collecting data.

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 and increase were not developed and not incorporated into the Center's overall documentation system, the IHCP.

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.

At San Antonio SSLC, data were reported for psychiatric indicators, which were typically identical to the identified PBSP target behaviors. One individual, Individual #390, had indicators identified that were not identical to the behavioral health target behaviors. There were no data reported regarding these identified psychiatric indicators. Eight individuals had data regarding indicators for decrease, those that were identical to behavioral health target behaviors, that were reliable. The 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.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: The indicators for CPE content and admission notes scored higher than ever before (indicators 14 and 15). Some inconsistencies in psychiatric diagnoses were present in about half of the cases. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 7	389	95	68	16	358	257	390	142
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.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 1/1								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.	56% 5/9	1/1	1/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1

Comments:

14. The Monitoring Team looks for 14 components in the CPE. Eight evaluations included all of the required components. One evaluation was missing two elements, appropriate laboratory examination results and an adequate bio-psycho-social formulation.

15. For the individual admitted in the two years prior to the onsite review, Individual #390, the CPE was performed on the day of admit and updated approximately three weeks later. There was a nursing admission note on the day of admission. There was an admission note from the PCP on the day after admission with the AMA completed approximately three weeks later.

16. There were four individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #95, Individual #16, Individual #358, and Individual #390. In two examples, regarding Individual #358 and Individual #16, the psychiatric diagnoses

were inconsistently documented in the psychiatric clinical notes, specifically diagnoses that were included in the annual CPE were not included in the quarterly documentation, but there was no notation regarding the removal of the diagnosis.

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

Summary: Annual psychiatry updates/evaluations were completed for all individuals, a nice improvement from previous reviews. The content was missing three to six components. They were, however, submitted on time and with sustained high performance, this aspect of ISP preparation (indicator 19) might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 7	389	95	68	16	358	257	390	142
17	Status and treatment document was updated within past 12 months.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

17. Eight individuals required annual evaluations. All 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 annual evaluations were missing three to six of the required elements.

19. All individuals in the review group had an annual evaluation completed or submitted to the ISP team within the required time frame.

20. The psychiatrist attended the ISP meeting for one 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, 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: One of two PSPs were submitted. The one that was submitted met criteria. For the other individual, who was on the list of individuals who had a PSP, the Center wrote "No data to report." This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	50% 1/2									

Comments:
22. The PSP was requested for two individuals, Individual #362 and Individual #128. The documentation of the plan regarding Individual #362 was comprehensive. There was no document provided for review regarding Individual #128.

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

Summary: Indicator 29, regarding content of the consent slipped to 11% (1/9). Given past high performance, the Monitor will leave this in the category of requiring less oversight, but improvement/correction needs to occur for it to remain in this category after the next review. See the comments below. The risk benefit discussion also needed improvement. On the positive, references to alternate and/or non-pharmacological interventions had improved to almost all of the individuals. Indicators 30 and 31 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.										

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.	78% 7/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
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:

29. The consent forms included adequate medication side effect information in one example. Eight examples did not have adequate medication side effect information included on the consent forms. For example, the consent forms regarding Individual #7 did not include the significant medication interaction between Tegretol and Luvox, where concurrent administration can result in alterations in the Tegretol level. Seven individuals were prescribed atypical antipsychotic medications. The consent forms for these medications did not include the risk of abnormal movements, dyskinesia, or tardive dyskinesia.

30. The risk versus benefit discussion was included in the consent forms in all examples, but it was essentially the same for all individuals and did not address the specific risk/benefit for the medications prescribed or individual for whom it was written.

31. The consent forms for seven of the individuals in the review group included alternate, individualized, non-pharmacological interventions.

Psychology/behavioral health

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

Summary: San Antonio SSLC scored 100% on indicator 5 for the first time (that is, the first 100% score for any SSLC for this indicator), an improvement from 75% at the last review. It was good to see this important foundational aspect of behavioral programming and treatment being now a regular part of the BHS/PBSP program.

#	Indicator	Overall Score	Individuals: 7	389	95	68	16	358	257	390	142
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
5. All individuals had interobserver agreement (IOA) and data collection timeliness (DCT) data that indicated that the data were reliable. This represents an improvement in the reliability of the PBSP data from the last review when 75% of the data were judged to be reliable. There were no instances of target behaviors observed by the Monitoring Team that were not recorded/entered in the data system.

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:
Criteria for indicators 1-9 were met for Individual #257, Individual #390, and Individual #142. Therefore, the remainder of the indicators in psychology/behavioral health were not rated for them.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.												
Summary: San Antonio SSLC has maintained similar performance for six consecutive reviews on this indicator, that is, criteria were met for all individuals except one in each of these reviews.			Individuals:									
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
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.									
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	1/1	1/1	0/1			

Comments:
15. Individual #358's current PBSP did not clearly address all of the functions identified in his functional assessment. Additionally, his 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: Although some improvement was noted, Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
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, these indicators 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.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	67% 6/9	1/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1
Comments: c. As discussed in further detail below, for three individuals, IDTs defined the frequency of interval medical reviews (IMRs) for both of the reviewed risk areas in accordance with current standards of practice, and accepted clinical pathways/guidelines. For other individuals, for one or more of the risk areas, the stated frequency was not consistent with their level of risk/need, or IDTs had not defined the frequency. For three of these individuals, PCPs completed quarterly IMRs, which was consistent with their level of need.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the annual and interval medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall	7	389	346	400	215	357	255	362	226

		Score									
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, 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.	28% 5/18	1/2	1/2	0/2	0/2	1/2	0/2	0/2	0/2	2/2

Comments: a. Problems varied across the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, social/smoking histories, childhood illnesses, 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 updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include, as appropriate, family history, pertinent laboratory information, and plans of care for each active medical problem.

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 #7 – constipation/bowel obstruction, and seizures; Individual #389 – osteoporosis, and seizures; Individual #346 – other: hypertension, and diabetes; Individual #400 – other: Vitamin D deficiency, and constipation/bowel obstruction; Individual #215 – cardiac disease, and urinary tract infections (UTIs); Individual #357 – diabetes, and neurological; Individual #255 – cardiac disease, and constipation/bowel obstructions; Individual #362 – other: tobacco use disorder, and cardiac disease; and Individual #226 – diabetes, and aspiration/respiratory compromise].

The IMRs that followed the State Office template, provided necessary updates related to the risks reviewed, and modified plans of care, when needed, included those for: Individual #7 – seizures, Individual #389 – osteoporosis, Individual #215 – cardiac disease, and Individual #226 – diabetes, and aspiration/respiratory compromise.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

Summary: Although more work is needed, since the last review, some continued improvement occurred with regard to IDTs defining in IHCPs the frequency of interval medical reviews, and basing their decisions on the individual's level of risk and related guidelines. As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
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	33% 6/18	2/2	1/2	0/2	0/2	0/2	1/2	1/2	0/2	1/2

	considerations.										
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	56% 10/18	2/2	2/2	0/2	1/2	1/2	1/2	1/2	0/2	2/2

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 #7 – constipation/bowel obstruction, and seizures; Individual #389 – osteoporosis, and seizures; Individual #346 – other: hypertension, and diabetes; Individual #400 – other: Vitamin D deficiency, and constipation/bowel obstruction; Individual #215 – cardiac disease, and UTIs; Individual #357 – diabetes, and neurological; Individual #255 – cardiac disease, and constipation/bowel obstructions; Individual #362 – other: tobacco use disorder, and cardiac disease; and Individual #226 – diabetes, and aspiration/respiratory compromise).

The following IHCPs included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations: Individual #7 – constipation/bowel obstruction, and seizures; Individual #389 – seizures; Individual #357 – neurological; Individual #255 – constipation/bowel obstructions; and Individual #226 – aspiration/respiratory compromise.

b. Since the last review, continued improvement was noted with regard to IDTs' inclusion in IHCPs of action steps defining the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. IDTs had done so for the following individuals' risk areas: Individual #7 – constipation/bowel obstruction, and seizures; Individual #389 – osteoporosis, and seizures; Individual #400 – constipation/bowel obstruction; Individual #215 – cardiac disease; Individual #357 – neurological; Individual #255 – constipation/bowel obstructions; and Individual #226 – diabetes, and aspiration/respiratory compromise.

Although the following individuals' ISPs/IHCPs defined the frequency as six months, given the severity of the individuals' level of risk, this frequency was not sufficient to meet their needs: Individual #346 – other: hypertension, and diabetes; Individual #255 – cardiac disease; and Individual #362 – cardiac disease. For the remaining risk areas, IDTs either had not developed IHCPs for individuals' risks, or they had not included an action step related to the need for interval medical reviews.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Overall, the quality and timeliness of assessments had improved. The Center should continue its focus on improving the quality of dental exams and summaries. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
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 with this indicator, it moved to the category of 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 ISP meeting.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	Due to the Center's sustained performance with this indicator, it moved to the category of requiring less oversight.									
b.	Individual receives a comprehensive dental examination.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	56% 5/9	1/1	0/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1

Comments: a.ii. For eight of the nine individuals reviewed, successful/completed annual dental exams occurred in a timely manner, indicating that, since the previous review, progress had been made in linking the assessments to the ISP dates.

b. Overall, the quality of assessments had improved. It was positive that for two of the nine individuals reviewed for this indicator, the dental exam 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;
- Treatment provided/completed; and,
- An odontogram.

Most, but not all included:

- An oral cancer screening; and,
- A summary of the number of teeth present/missing.
- Periodontal charting.

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

- Information regarding last x-ray(s) and type of x-ray, including the date; and,
- A treatment plan that is sufficient to meet the needs of the individual. This was particularly problematic for individuals with

periodontal disease.

c. It was positive that five of the nine dental summaries reviewed included all of the required components. It was also good to see that all of the remaining 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;
- Treatment plan, including the recall frequency.
- 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:

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

In its comments on the draft report, the State disputed this finding, and referenced portions of the dental summaries that staff believed showed compliance with the measure. The Monitor did not make changes to the original findings. The following provide the specific reasons for the noncompliance:

- For Individual #389, the ADS discussed periodontal disease and cardiac risk, and aspiration pneumonia. These were the generic statements submitted for most individuals. That section should have discussed the use of Prolia with this individual and its impact on dental health and treatment;
- For Individual #400, the Dentist included the same generic statement related to periodontal disease and cardiac risk. The individual had significant GERD that required treatment with a proton pump inhibitor (PPI) and H2 antagonist. GERD can have a significant impact on oral health. Moreover, the medications he was prescribed can cause dry mouth, which also leads to dental issues;
- For Individual #362, there was no discussion in the summary of the individual's tobacco use disorder and its impact on oral health and teeth; and
- For Individual #226, the Dentist did not discuss the impact of diabetes on oral health, or the individual's GERD, but rather just included the generic statement about periodontal disease and aspiration pneumonia.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.	
Summary: For seven out of nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments. 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	7	389	346	400	215	357	255	362	226
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	44% 4/9	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1

Comments: a.i. and a.ii. Many of the individuals reviewed had timely annual comprehensive nursing reviews and physical assessments. Problems included:

- On 4/10/19, Individual #357's IDT held her annual ISP meeting. The most recent annual nursing assessment was dated 3/22/18.
- An annual physical assessment was not submitted for Individual #226.

With regard to quarterly nursing record reviews and physical assessments, examples of problems included:

- For three individuals, one or more of the quarterly physical assessments were not available/submitted (i.e., Individual #7, Individual #357, and Individual #226).
- Others were late, or did not cover a quarter.

Outcome 4 – Individuals have quality nursing assessments to inform care planning.

Summary: Work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions, as well as thorough annual and quarterly physical assessments. It is essential in annual and quarterly assessments that nurses provide specific dates. At times, individuals' clinical stories were unclear, because dates of various events or summary data were missing. In addition, when individuals experience changes of status, nurses need to consistently complete assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	Individual receives a quality annual nursing record review.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
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.	22% 2/9	1/1	0/1	0/1	0/1	0/1	0/1	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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	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.	50% 5/10	0/1	2/2	0/1	N/A	1/2	0/1	0/1	1/1	1/1

Comments: a. As noted above, an up-to-date annual nursing assessment was not available/submitted for Individual #357. It was positive that all of the remaining annual nursing record reviews the Monitoring Team reviewed included, as applicable, the following:

- Active problem and diagnoses list updated at the time of annual nursing assessment (ANA); and
- List of medications with dosages at the time of the ANA; and
- Lab and diagnostic testing requiring review and/or intervention.

Most, but not all included, as applicable:

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

The components on which Center staff should focus include:

- Family history;
- Procedure history;
- Immunizations; and
- Allergies or severe side effects to medication.

b. Nurses completed annual physical assessments that addressed the necessary components for only two of the nine individuals reviewed. Numerous concerns were identified for the remaining individuals. For example, at times, breast exams were not completed, assessments for various body systems were missing (e.g., reproductive, skin integrity, GI, neurological, etc.). For one individual with a G-tube, no physical assessment was found of his ostomy site.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 specific risk areas, and as available, the IHCPs to address them (i.e., Individual #7 – seizures, and constipation/bowel obstruction; Individual #389 – respiratory compromise, and falls; Individual #346 – diabetes, and fractures; Individual #400 – dental, and GI problems; Individual #215 – respiratory compromise, and constipation/bowel obstruction; Individual #357 – skin integrity, and falls; Individual #255 – GI problems, and aspiration; Individual #362 – choking, and cardiac disease; and Individual #226 – infections, and weight).

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 example, nurses did not include complete status updates in annual or quarterly assessments, including relevant clinical data (i.e., the only exception was for Individual #400 – dental). Nurses also did not analyze this information, including comparisons with the previous quarter or year, and/or make recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

In addition, it is essential in annual and quarterly assessments that nurses provide specific dates. At times, individuals' clinical stories were unclear, because dates of various events or summary data were missing.

d. It was positive that the quarterly nursing record reviews the Monitoring Team reviewed for this indicator all included the following, as applicable:

- Active problem and diagnoses list updated at the time of the quarterly assessment;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Consultation summary; and
- Lab and diagnostic testing requiring review and/or intervention.

Most, but not all of the quarterly nursing record reviews the Monitoring Team reviewed included, as applicable:

- Tertiary care.

The components on which Center staff should focus include:

- Family history;
- Procedure history;
- Social/smoking/drug/alcohol history;
- Immunizations; and
- Allergies or severe side effects to medication.

e. For two individuals, the most recent quarterly physical assessments were not available/submitted (i.e., Individual #7, and Individual #226). Problems varied with regard to the quality of quarterly physical assessments. For example, missing components included waist circumferences, follow-up assessments for abnormal findings (e.g., vital signs), reproductive assessments, breast exams, weight records, and falls scores.

g. The following provide examples of individuals' changes of status for which nurses completed assessments in accordance with applicable nursing guidelines:

- According to a nursing IPN, dated 2/28/19, at 6:35 a.m., and corresponding IView entries, dated 2/28/19, at 6:35 a.m., Individual #389 had decreased meal intake, an increased pulse, coughing, and decreased right lower lobe lung sounds. The nurse followed applicable nursing guidelines, including physician notification with orders that included a stat chest x-ray. The provider ordered Azithromycin.
- In an IPN, dated 6/7/19, at 2:43 p.m., and IView entries, dated 6/7/19, at 1:00 p.m., a nurse documented that staff reported that Individual #389 fell. Specifically, the nurse documented: "DSP reported as he came to aid [Individual #389] to sit he discovered he needed check and change as he stood him up, he lunged forward losing his balance and fall [sic] to the ground. He attempted to help/catch [Individual #389] DSP fell he lost balance attempting to assist him." In response to the fall, the nurse followed relevant guidelines in conducting the initial assessment.
- In an IPN, dated 2/8/19, at 1:45 a.m., and IView entries, dated 2/7/19, at 8:13 p.m., a nurse documented: "[Individual #215] dx [diagnosed] with influenzas type A on 2/6/19. Adventitious lung sounds noted prior to RT [respiratory therapy] tonight. The objective findings noted oxygen saturation 92%, inspiratory wheezing noted in five lobes (anterior sounds noted)." The nursing IPN indicated that the nurse notified the PCP, and received orders for a chest-ray, 2 liters (l) of supplementation oxygen, and morning labs. On 2/8/19, at 3:22 a.m., a nurse documented notification of the PCP for oxygen saturation rates of 93 to 94% on 2l of oxygen, a pulse rate of 150, and a blood pressure reading of 86/63. The individual was transferred to the ED, and subsequently admitted for respiratory distress and tachycardia. Based on the individual's signs and symptoms, nursing staff followed applicable assessment guidelines for respiratory compromise and abnormal vital sounds. He was admitted to the intensive care unit (ICU) for cardioversion, due to an atrial flutter.
- On 2/20/19, nursing staff documented that Individual #362 had a choking episode at 12:22 p.m., during which he was observed without respirations or cough. Abdominal thrusts relieved the obstruction. Nursing staff followed applicable guidelines and current standards of practice for emergent respiratory distress/aspiration, including notification to the PCP.
- According to a nursing IPN, dated 5/17/19, at 3:52 p.m., Individual #226 was tachycardiac, tachypneic, and febrile. The nurse notified the PCP and the induvial was sent to the ED, where she was admitted to the ICU and diagnosed with sepsis, secondary to aspiration pneumonia, and placed on intravenous (IV) antibiotics. Based on the documented signs, symptoms, and clinical findings, the nurse followed applicable nursing guidelines.

The following provide a few of examples of concerns related to nursing assessments conducted in relation to individuals' changes of status:

- A nursing IPN, dated 6/5/19, at 4:31 p.m., and IView entries, dated 6/5/19, at 2:20 p.m., noted that Individual #7 had a seizure lasting three minutes. The IPN indicated she reviewed IM medication for her seizure activity. The IView entries indicated that the individual experienced apneic periods, bit her cheek and tongue, and showed signs of disorientation (i.e., remainder of words cut off). The entries indicated that the individual had a change in mental status, which was described as an acute change from baseline (this was not explained elsewhere). The individual also had a low oxygen saturation rate of 86. Based on the significant findings of the nursing assessment, nursing staff did not follow applicable nursing guidelines that required notification of the physician.
- According to a nursing IPN, dated 5/14/19, at 10:52 a.m., the Campus Coordinator came to the nurses' station to report that Individual #346 fell on his right side in the living area at 8:00 a.m. In the IPN, the nurse documented that the individual refused an assessment three times. However, the IPN did not include a respiratory rate, and no corresponding IView entries were submitted. Although the nurse documented in the IPN: "notify Dr… during rounds individual has no new orders at this time," at 10:25 a.m., the individual left for an orthopedic appointment due to a swollen ankle. Based on the documentation submitted, the nurse did not complete and/or document an assessment consistent with the nursing assessment guidelines for a fall. Moreover, no corresponding PCP entry was submitted to show a medical assessment prior to the appointment.
- For Individual #215, a nursing IPN, dated 6/12/19, at 6:01 a.m., stated: "KUB [abdominal x-ray] done at 0550 by mobile x-ray," but provided no additional information regarding the rationale. A nursing IPN, dated 6/12/19, at 2:31 p.m., stated in its entirety: "resident sitting in w/c [wheelchair] alert and responsive to stimuli. Resp [respirations] even and unlabored. 0 output from suprapubic cath. RN was informed. Per RN MD waiting for results from KUB done this morning." In a nursing IPN Addendum, dated 6/12/19, at 2:36 p.m., the nurse documented reading the KUB results to the MD, as well as a new order: "Give Fleet enema x 1 today, then tomorrow give another Fleet enema for large amount of rectal stool present." Based on review of IView entries for 6/12/19, nursing staff did not conduct any abdominal assessments, which were warranted, given that the individual was being treated for constipation. Based on scant documentation and the finding of no output from the suprapubic catheter, as well as a positive KUB finding, nursing staff did not follow standards of practice for performing abdominal assessments, assessing intake and output, and reviewing the date of the individual's last bowel movement.
- On 5/8/19, at 8:30 a.m., staff reported that Individual #357 fell as a result of tripping over her own feet, and hit her head. Based on documentation submitted, nursing staff did not follow assessment guidelines related to the fall and/or the potential head injury.
- For Individual #255, a nursing IPN, dated 6/24/19, at 10:27 a.m., stated: "peg tube assess prior to 0930 feeding being given, some air and liquid bubbles noted from site upon auscultation/aspiration." The record indicated the nurse notified the PCP at 9:42 a.m. The PCP gave orders to "hold feeding and medications, make an appointment for GI for peg tube replacement and see if dietary can supplement [Individual #255] until peg tube is replaced." A nursing IPN, at 2:44 p.m., documented a call to the Dietician at 11:09 a.m., with a return call at 11:59 a.m. The note indicated that Habilitation Therapy staff did not advise giving the individual anything by mouth (PO). At 12:03 p.m., the nurse notified the PCP. The IPN documented the PCP was aware, but that the individual was going to receive pleasure feeding due to issues with the PEG-tube, and the PCP indicated that nursing staff could give the individual medication PO with the pleasure feeding. The record indicated nursing staff crushed the medication and placed it in pudding. At 1:53 p.m., the PCP ordered four ounces of Coca Cola with a slow push. The nurse attempted 10 cubic centimeters (cc) slow push via the PEG-tube, and noted it leaked from the side of the stoma. At 2:06 p.m.,

the nurse notified the PCP and the individual was sent to the ED. Based on the order for an alternate route for his medications due to a malfunctioning PEG-tube, the nursing assessment should have included a temperature as part of vital sign assessments, as well as oxygen saturations, and lung sounds, but based on documentation submitted, nursing staff completed none of these assessments before or after the alternate route was used. In addition, nursing standards of care for administering fluids via a G-tube require nursing staff to use the gravity and not the push method.

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	7	389	346	400	215	357	255	362	226
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. The IHCPs reviewed were missing key nursing supports. For example, RN Case Managers and IDTs generally had not individualized interventions in relevant nursing guidelines and included in the action steps of IHCPs specific assessment criteria for regular nursing assessments at the frequency necessary to address conditions that placed individuals at risk [e.g., if an individual was at risk for skin breakdown/issues, then an action step(s) in the IHCP that defines the frequency for nursing staff to assess the color, temperature, moisture, and odor of the skin, as well as the drainage, location, borders, depth, and size of any skin integrity issues]. In addition, often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause or etiology of the at-risk or chronic condition (e.g., if an individual had poor oral hygiene, a nursing intervention to evaluate the quality of the individual's tooth brushing, and/or assess the individual's oral cavity after tooth brushing to check for visible food; if an individual's positioning contributed to her aspiration risk, a schedule for nursing staff to check staff's adherence to the positioning											

instructions/schedule; if an individual's weight loss was due to insufficient intake, mealtime monitoring to assess the effectiveness of adaptive equipment, staff adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.). Significant work is needed to include nursing interventions that meet individuals' needs into 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: In general, the PNMT documentation was clearly written, and thorough, and it was easy to follow the sequence of events in a succinct manner. However, often, individuals' needs necessitated the completion of comprehensive assessments, but the PNMT only completed a review without providing reasoned clinical justification. The PNMT also needs to improve the timeliness of assessments/reviews. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	17% 1/6	0/2	N/A	0/1	N/A	N/A	0/1	0/1	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	33% 2/6	0/2		0/1			1/1	0/1	1/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/3	0/1		N/A			0/1	0/1	N/A	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	33% 2/6	1/2		0/1			0/1	0/1	1/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	33% 1/3	N/A		0/1			N/A	1/2	N/A	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	17% 1/6	0/2		0/1			0/1	1/1	0/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status;	60% 3/5	1/1		0/1			1/1	0/1	1/1	

	• 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.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3	0/1		N/A			0/1	0/1	N/A	

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

- On 12/13/18, the PNMT conducted a review of weight and falls for Individual #7. Based on the documents submitted, the Monitoring Team could not determine when the IDT made the referral.
  - Between 6/29/18 through 9/6/18, the PNMT discussed concerns related to Individual #7's weight loss a number of times, but these were informal discussions, and not reviews. During this time, she remained within her estimated desired weight range (EDWR) (i.e., 108 to 132 pounds), but experienced weight loss (i.e., January 2018 - 122.2 pounds, February 2018 - 120.4, March 2018 - 123.4, April 2018 - 116.2, May 2018 121.8, June 2018 - 116.6, July 2018 – 117, July to August 2018 - 6.6-pound weight loss to 110.4). In August 2018, the IDT made some adjustments to the individual's intake. Specifically, they reinstated Ensure if she ate less than 50% of her meals, and offered double portions and snacks. She gained some weight in August to September (i.e., gained 4.6 pounds to 115), but had not returned to her initial baseline from earlier in the year (i.e., 120 to 123 pounds in January through March). The PNMT documented no further discussion until the December review after additional weight loss (i.e., October 111.2, November 114.6, and December 107.4). This weight loss occurred despite increases to triple portions and two Ensure puddings as morning and afternoon/evening snacks. No evidence was found to show the IDT nutritionist conducted an assessment making only two brief notes, dated 8/15/18 and 11/29/18. Although this is a concern, Individual #7's weight issues improved with diet order changes. The PNMT conducted a review that met criterion, though it was not signed by any team member other than the SLP, and the PNMT continued to monitor the individual.
  - From 7/15/18 through 9/21/18, per PNMT documentation, Individual #7 experienced the following occurrences: two falls when a peer pushed her (7/15/18 and 8/29/18); in one instance, staff found her on the ground (8/11/18); she plopped to the ground on purpose once (8/16/18); she fell twice 8/21/18 and 9/18/18; and tripped twice 9/4/18 and 9/21/18 (did not specify whether she merely tripped or also fell). Although she did not technically meet criteria for review, on 9/27/18, the PNMT discussed these occurrences, and decided to observe her at work where several of these events occurred. On 10/3/18, the PNMT conducted observations, noting her shoes were on the wrong feet. The PNMT recommended the IDT order new shoes, and provide in-service training to staff regarding environmental hazards. A subsequent PNMT note, on 12/13/18, reported that she had 16 falls in six months (though only 15 dates were listed in notes written on 9/27/18 and 12/13/18), and provided some detail about the causes, such as peers pushing her with some instances of Individual #7 instigating the peer-to-peer aggression, drops to the ground, and at least 10 were "true falls." Additional falls had occurred on 10/14/18 (escaping aggressive peer), 10/25/18 (tripped on shoes that were on the wrong feet), 10/26/18, 11/26/18 (trip), 11/28/18 (pushed by peer), 12/3/18 (hit back of head, and sustained a one-inch cut), and 12/10/18 (trip). Per video review of a fall in November, she slid off the couch twice intentionally, although the report stated she tripped over a wheelchair. Records reviewed also showed an additional fall on 9/22/18, ten falls from December 2018 to March 2019, including: 12/15/18 (trip), 12/16/18

(pushed), 12/19/18 (trip), 1/3/19 (seizure), 1/26/19 (found on floor), 2/23/19, 2/27/19, 3/2/19, 3/5/19, and 3/25/19. The individual fell four more times between April and early June (i.e., 4/13/19, 5/17/19, 6/9/19, and 6/18/19 - hit her head). On 6/5/19 and 7/7/19, she had additional seizures. On 1/14/19, she fractured her finger (i.e., cause unknown), and on 4/16/19, she fractured her right lateral malleolus (i.e., following a "slide" from her seat to the ground). Since 2/7/19, the PNMT had not documented additional review/discussion. Given the ongoing nature of the falls and the serious injuries, the PNMT should have conducted a comprehensive assessment

In its comments on the draft report, the State disputed the finding related to Indicator f, and stated: "Please see evidence of BHS inclusion in the PNMT review in document TX-SA-1908-11.73.SB on page 14 toward the bottom of the page and page 17, third bullet." The findings of non-compliance relate not only to the lack of documentation to show that various clinicians participated and approved/agreed with the assessment, but also that Individual #7 did not receive the reviews/assessments she needed. As such, she did not have the benefit of the collaboration of the necessary disciplines.

- For Individual #346's risk for fractures, no current IHCP was found. According to the IRRF, in 2018, his IDT rated him at low risk, but his status changed in 2019. In February 2019, he fractured his left ankle while on a visit to a day habilitation program in the community. On 5/14/19, on the day before his ISP meeting, he experienced a second fracture to his left leg. He required surgery for both fractures. Both resulted from falls, potentially related to seizure-like activity, which the individual reported as shaking. The IRRF indicated that he had "Numerous falls in the last year," including falls on 12/19/18, 1/30/19 (described as "fall on right ankle," per ISPA held on 2/12/19), 1/12/19, 4/8/19, 5/8/19, and 5/14/19 (i.e., ankle fracture on 2/11/19, due to fall not listed). An ISPA indicated that he had no history of seizures, and the IDT hypothesized he might be anxious about transitioning to the community. On 5/14/19, the second fracture reportedly was related to a fall, when he was getting up from the sofa, and his "right leg went out." This was a fracture to the left leg with fracture above his left ankle per ISPA held on that date. Staff observed him fall on his right side, yet the break was on the left. According to the ISPA, the RN was notified that the fracture was higher on the left leg rather than the ankle, and it was not clear if the fractures were related to this fall or a previous one. The PCP was present at the ISPA meeting, and indicated that there was no fracture. However, the direct support professional, who attended the orthopedic appointment that day, stated that the orthopedist determined that there was a fracture in the upper tibial plateau above the plate in his leg from a previous fracture. Despite the fact that this was his second fracture in three months, his IDT did not refer him to the PNMT. Based on documents submitted, the PNMT did not conduct a review.
- For Individual #357, referral to the PNMT for falls was indicated in November 2017, December 2017, July 2018, August 2018, and September 2018. Between 4/11/18 through 3/9/19, she experienced as many as 63 falls. With an additional 15 since that time (i.e., on 3/26/19, 3/20/19 x 2, 4/9/19, 4/17/19 x 3, 4/27/19, 5/4/19, 5/8/19, 5/19/19, 5/24/19, 5/30/19, 5/31/19, and 6/9/19). On 10/25/18, the PNMT conducted a review, which included some important information, and offered the IDT some reasonable recommendations. However, the PNMT did not include Behavioral Health Services (BHS) staff in the review.

  In its comments on the draft report, the State indicated: "The following evidence of multidisciplinary involvement within PNMT review/assessments can be found in submitted documention [sic], TX-SA-1908-11.73:
  - Behavioral Health: VM (BHS) input on page 98 near top of page, on page 101, 6th bullet, and item #7 in the plan section.
  - Pharmacy: PharmD input on page 99, 1st bullet.

- Medical: Physician input on page 100 under letter B, 4th bullet, and on Page 101, 7th bullet."

The concern that the PNMT was reviewing was falls, and there were significant concerns related to the long-term effects of the individual's head banging, as well as use of medications sides effects. Evidence should have shown that BHS staff participated in the assessment and contributed to the problem-solving. Based on review of the documentation to which the State's comments pointed, BHS staff were not listed as participants (as addressed elsewhere no signatures were available to show participants' participation), and the information included in the assessment did not show an integrated approach to problem-solving. The following are the excerpts to which the State referred:

> "Behavior & BHS input: [Individual #357] is at high risk in the area of Behavioral Health. A PBSP is in place to address aggression, SIB, and inappropriately toileting with functions identified as escape and tangible. Her replacement behavior is to complete a full work task. She has frequent head banging. Her aggression has decreased since her admission, but her head banding has not."
>
> "6. BHS will add new precursor behaviors (vocalizations, clapping hands, and stomping feet) to PBSP.
> 7. IDT to discuss the possibility of reinstating a helmet for head banging. BHS to discuss with supervisor."

Similarly, the Pharm D was not listed as a participant, and the input the State referenced appeared to be cut and pasted from the annual medical assessment and/or QDRR.

In addition, with the continued falls, the PNMT did not conduct a comprehensive assessment, and their rationale for not doing so was insufficient. Specifically, they said that most of her falls did not result in injuries, and that the IDT and PNMT put a number of actions in place. Given that the next fall could result in serious injury and/or death, the PNMT's rationale was faulty. In addition, by putting interventions in place without an assessment to properly analyze data, review the implementation of and efficacy of current interventions, and develop goals/objectives to allow assessment of new interventions, the PNMT/IDT had not approached the prevention of the falls in a methodical manner, which decreased the likelihood of properly addressing the individual's significant risk. Moreover, given that a number of the interventions had been in place for at least six months, and the individual continued falling, their implementation and/or their efficacy was questionable.

- On 2/11/19, the PNMT conducted a review for Individual #255. From 10/19/18 to 11/1/18, he was hospitalized for bacterial pneumonia and PEG- tube placement. He was weaned from supplemental oxygen and gradually resumed oral eating working up to double portions and taking medications orally on 11/15/18. From 12/23/18 to 1/18/19, he was hospitalized with aspiration pneumonia, and had a tracheostomy placed. He pulled it out a few times, and it was removed prior to discharge. It was not clear why the PNMT did not complete a comprehensive evaluation when he was discharged the first time. The review was not completed for 24 days after the second hospitalization and over three months after tube placement (103 days). In the draft report, the Monitoring Team indicated that no Registered Nurse (RN) post-hospitalization review was submitted for his hospitalization. In its comments on the report, the State disputed this finding, and pointed the Monitoring Team to the related documentation. After review, the Monitoring Team revised the score to reflect that for the first hospitalization, the RN completed a review, but evidence was not available to show that the PNMT discussed it; and for the second hospitalization, the RN completed the review, and the PNMT did discuss it.

- On 1/14/19, Individual #362 choked on pizza. After he choked a second time, on 2/20/19 on hamburger, the PNMT conducted a review, on 2/20/19. It was good to see that the review was thorough with follow-up monitoring to ensure that the Dining Plan was effective with the addition of prompts. The PNMT determined the etiology or cause of the choking was the individual's tendency to take large bites and pocket food. The PNMT discussed the potential impact of "hypersalivation." Although the PNMT did not mention whether or not poor oral hygiene or dental pain were issues, the individual did not appear to have issue with other solid foods. On 1/15/19, the IDT modified the Dining Plan, and on 2/22/19, staff in-service training was completed with monitoring. On 3/7/19, the PNMT completed follow-up regarding the monitoring findings, with subsequent follow-up on 3/28/19, to evaluate peanut butter and jelly sandwiches at snack time. The PNMT determined these items were too thick, and on one occasion, the individual did not receive juice. They decided to limit snack sandwiches to meat and cheese to reduce the individual's choking risk. Further monitoring indicated that staff were following the Dining Plan.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments. Currently, PNMT documents often included a list of "participants" within the document. Given that PNMT members are licensed clinicians, the Center needs to have a mechanism to verify the participation of each clinician in the PNMT assessment process. The author or person entering information could potentially populate the list of "participants" without those clinicians having any role in the process or even knowing that they are listed as "participants." Other entries in IRIS provide a "signature" of sorts, because the system identifies the author of each entry as the user that entered the system using a password. Such entries are also time-stamped. Given the ongoing challenges with IRIS related to the inability to have more than one user "sign" a document, the State should propose a mechanism to allow this verification (i.e., allowing one user to simply include the names of "team members" at the bottom of the report does not suffice).

h. As noted above, three individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #7 for falls, Individual #357, and Individual #255).

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. It was concerning that for some individuals with PNM-related needs/risks, current IHCPs to address their needs were not available/submitted. Often, IHCPs did not include specific PNM interventions, or included general statements such as "implement PNMP" without details about the interventions staff needed to implement. Significant improvement is needed with regard to improving the quality of IHCPs. On a positive note, some improvement was noted with regard to the quality of the PNMPs. With minimal effort and attention to detail, the Habilitation Therapy staff should be able to continue to make the needed corrections, and by the time of the next review, the Center could make additional progress on complying with this requirement. These indicators will continue in active oversight.	Individuals:

#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
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).	6% 1/17	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/1	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1	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.	44% 4/9	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	6% 1/17	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/1	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	6% 1/17	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/1	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2

Comments: The Monitoring Team reviewed 17 IHCPs, as available, 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 #7 – weight, and falls; Individual # 389 – aspiration, and falls; Individual #346 – fractures, and weight; Individual #400 – choking, and falls; Individual #215 – skin integrity, and aspiration; Individual #357 – choking, and falls; Individual #255 – falls. and aspiration; Individual #362 – choking; and Individual #226 – aspiration, and skin integrity.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exception was for Individual #255 – aspiration. It was concerning that for some individuals with PNM-related needs/risks, current IHCPs to address their needs were not available/submitted (e.g., Individual #7 – weight; Individual #346 – fractures, and weight; and Individual #400 – falls). Often, IHCPs did not include specific PNM interventions, or included general statements such as "implement PNMP" without details about the interventions staff needed to implement.

b. Overall, ISPs/IHCPs reviewed did not include preventative physical and nutritional management interventions to minimize the individuals' risks.

c. All individuals reviewed had PNMPs and/or Dining Plans. It was positive that for Individual #346, Individual #357, Individual #255, and Individual #362, the PNMPs thoroughly addressed the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans reviewed.

- It was positive that Habilitation Therapy staff reviewed and updated the nine PNMPs/Dining Plans within the last 12 months,

and as applicable to the individuals' needs, the PNMPs/Dining Plans included:
    - Risk levels related to supports and individual triggers, if applicable;
    - Photographs;
    - Descriptions of assistive/adaptive equipment;
    - Transfer instructions;
    - Bathing instructions;
    - Toileting/personal care instructions;
    - Mealtime instructions;
    - Medication administration instructions; and
    - Oral hygiene instructions.
- As applicable to the individuals, most, but not all of the PNMPs reviewed included:
    - Positioning instructions;
    - Mobility instructions; and
    - Handling precautions or moving instructions.
- The component of the PNMPs on which the Center should focus on making improvements includes:
    - Complete communication strategies.

With minimal effort and attention to detail, the Habilitation Therapy staff should be able to continue to make the needed corrections to PNMPs, and by the time of the next review, the Center could make additional progress on complying with this requirement.

e. The IHCP reviewed that identified the necessary clinical indicators was for: Individual #255 – aspiration.

f. The IHCP that identified triggers and actions to take should they occur was for: Individual #255 – aspiration.

g. The IHCPs reviewed often did not include action steps/interventions to define needed PNMP monitoring.

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	7	389	346	400	215	357	255	362	226
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.	100% 3/3	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A	1/1
b.	If it is clinically appropriate for an individual with enteral nutrition to	0%					N/A		0/1		N/A

	progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0/1									

Comments: a. and b. For Individual #215, and Individual #226, the IDTs provided clinical justification for the continuation of enteral nutrition, and provided the rationale for not moving the individual along the continuum to oral intake.

For Individual #255, the IDT also provided the justification for enteral nutrition. They developed a plan for moving the individual along the continuum. However, the initial plan essentially said he would return to full oral intake without providing a step-by-step plan in the IHCP, including clearly measurable outcomes and reasonably graded interventions necessary to meet the goals. The IDT rapidly progressed him to oral intake with double portions, and he was hospitalized with aspiration pneumonia. Although the second plan was better, it did not include graded strategies and clearly measurable outcomes.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.

Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. The quality of OT/PT assessments continues to be an area on which Center staff should focus. The new assessment template for OT/PT assessments from State Office was now in place and there is promise that this could improve the quality of the assessments. Of course, therapists need to utilize the corresponding guidelines to ensure that assessments are thorough and address individuals' strengths and needs. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's	64% 7/11	0/1	1/1	0/1	1/1	2/2	1/1	2/2	0/1	0/1

	needs.										
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	27% 3/11	0/1	0/1	0/1	1/1	0/2	1/1	1/2	0/1	0/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/7	0/1	0/1	0/1	N/A	0/1	N/A	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/2	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A

Comments: a. and b. Many individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status, which was positive, but many did not receive the type of assessment in accordance with their needs. Examples of concerns included, but were not limited to, the following:

- The OT/PT for Individual #7 should have considered completing a comprehensive assessment in 2018, but documented no rationale for not doing so. Similarly, Individual #226 had not had a comprehensive assessment since 2012, so she should have had one, or the therapists should have provided justification for not doing so.

- For Individual # 389, Individual #215, and Individual #255, assessments did not include evidence that both OTs and PTs participated in the evaluations.

  In its comments on the draft report, the State disputed these findings, and stated: "While the PT was the only one to enter information into IRIS, both OT and PT worked on the evaluation together. This can be evidenced by the fact that both the OT and PT are listed under the contributors section within the evaluation." The same issue arose and was addressed in the last

report. As the Monitor indicated in the final report for the last review: "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)." Hopefully, by the time of the next review, Center and/or State Office staff will have resolved this issue. The Monitor made no changes to the scores related to individuals receiving the type of assessment they needed.

- For Individual #346, the Center provided no evidence of a change of status assessment to address a loss of independent mobility secondary to the fracture of his left ankle.

- For Individual #362, the OT and PT conducted a mealtime observation and reviewed video of choking event that occurred on 2/20/19. In addition, the Center provided evidence of a mealtime observation conducted after a choking event occurred when out on pass with his sister on 1/12/19. However, he should have had an OT/PT assessment for the ISP held on 5/21/19.

  In its comments on the draft report, the State disputed this finding, and stated: "…the SLP and OT determined this choking incident is not related to a swallowing dysfunction therefore a formal OT/PT assessment was not warranted." Had the individual only had one choking incident that the therapists determined was not related to a swallowing dysfunction, then an assessment might not have been warranted. However, given that the individual had two choking events in short succession, an assessment should have been completed. In addition, the therapists had to make changes to his Dining Plan.

d. Overall, the Center needed to make significant improvements with regard to comprehensive assessments. None of the comprehensive assessments met all criteria for a quality assessment. The Center needed to continue to focus on all of the sub-indicators:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- 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;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and,
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

e. The Center also needed to make significant improvements with regard to updated assessments and needed improvement with all of the 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 pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- 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;
- 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);
- 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;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and,
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

The new assessment template for OT/PT assessments from State Office was now in place. The Monitoring Team reviewed assessments completed using the new format, as well as the sample and guidelines the Habilitation Therapies Department provided to the therapists. There is promise that this could improve the quality of the assessments, which has been an ongoing problem. Of course, therapists need to utilize the corresponding guidelines to ensure that assessments are thorough and address individuals' strengths and needs.

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: 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	Individuals: 7	389	346	400	215	357	255	362	226
a.	The individual's ISP includes a description of how the individual	22%	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1

	functions from an OT/PT perspective.	2/9									
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.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	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.	0% 0/6	N/A	N/A	N/A	N/A	0/3	N/A	0/3	N/A	N/A

Comments: a. Overall, The ISPs reviewed did not include concise, but thorough descriptions of individuals' OT/PT functional statuses. Therapists should work with QIDPs to make improvements. Examples of concerns included, but were not limited to, the following:

- The IDT for Individual #7 listed recommendations from the OT/PT assessment in her ISP, but provided no specific descriptions with regard to her functional status.
- For Individual #389, Individual #357, and Individual #362, the ISPs did not provide descriptions of the individuals' motor skill performance.
- Individual #346's ISP did not provide a description of his status prior to his surgical procedure or a clear statement of his current status.

b. Overall, ISPs for the individuals reviewed reflected that the IDTs did not document specific discussions about individuals' needs. Therapists should work with QIDPs to make improvements.

c. and d. Examples of concerns included:

- Overall, IDTs did not address individuals' OT/PT needs by including recommended interventions in ISP action plans.
- IDTs also did not hold ISPA meetings to review and approve OT/PT assessment recommendations for the initiation of or modification to therapy services and supports.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: Individuals reviewed often did not receive assessments in accordance with their needs. Significant work was also 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	Individuals:

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. The new assessment template for communication assessments from State Office was now in place, though, and it appeared to hold promise for improving the quality of the assessments in the future. These indicators will remain in active oversight.											
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
	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.	50% 4/8	0/1	1/1	0/1	0/1	0/1	1/1	1/1	N/A	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	56% 5/9	0/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental	0% 0/2	N/A	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A

	Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/6	0/1	N/A	0/1	0/1	0/1	0/1	0/1	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/2	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments: b and c. The following provides information about problems noted with regard to individuals receiving the type of assessment in accordance with their needs:

- For Individual #389, Individual #357, Individual #255 and Individual #226, the assessments did not provide evidence that a credentialed SLP completed them. Instead, the clinician who signed the assessments had credentials listed as a Recreation Therapist rather than an SLP with a Certificate of Clinical Competence (CCC-SLP). In its comments on the draft report, the State explained that this was an error in IRIS, and provided the license number to show a licensed SLP completed these assessments. After confirming the information online, the Monitor revised the scores. Given the importance of the accuracy of individuals' records, it is concerning that the State did not have a mechanism to identify and correct this or similar errors prior to the Monitoring Team identifying it.
- For Individual #346, the Center provided only a screening and did not submit evidence of a previous comprehensive evaluation. It was also not clear that the Center had provided a thorough articulation assessment to determine errors and potential for shaping or change/improvement.

  In its comments on the draft report, the State disputed this finding, and stated: "The state policy says that individuals will be screened for communication needs, including augmentative communication needs, within 30 days of admission and that comprehensive communication assessments will be completed according to the schedule set forth in the Communication Master Plan, or as indicated by need. Individual #346 did not require a previous comprehensive evaluation due to communicating wants and needs effectively. There also is no indication for additional articulation assessment for an individual who is functionally verbal and intelligible and the screen for Individual #346 states that he is intelligible 75-100% of the time with both familiar and unfamiliar listeners." The screening described him as having a phonological disorder. It did not provide examples or a rationale as to why or why not there was potential to remediate it, and/or that there was a need to remediate it.
- For Individual #400, the Center submitted a comprehensive assessment from 2016. The IDT indicated the rationale for not completing one was that there had been no change in his communication abilities, but this did not take into account any effort to implement a plan to improve those abilities. This was particularly pertinent because during the update, the clinician determined that Individual #400 would benefit from short term therapy to determine if he showed potential to use pictures versus speech.
- The IDT for Individual #215 did not state a rationale for not providing a new comprehensive assessment in 2019, even though the previous comprehensive assessment had been completed on 6/16/16. This was also the case for Individual #7, who had not had a comprehensive assessment since 2013.

d. As noted above, the Center did not submit a current comprehensive assessment for Individual #7, Individual #346, Individual

#215, Individual #400. Based on review of the documents submitted, it was concerning that none of the comprehensive assessments met criteria for any of the following sub-indicators:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

e. None of the three updates reviewed met all criteria, as applicable. The Center needed to continue to focus on all of 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;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- 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;
- 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.

The new assessment template for communication assessments from State Office was now in place. The Monitoring Team hopes that this might improve the quality of the assessments, which continues to be an ongoing and significant problem.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.											
Summary: Improvement is needed with regard to all of these indicators. To move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals' communication supports in ISPs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
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.	67% 6/9	1/1	1/1	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.	71% 5/7	1/1	0/1	N/A	0/1	1/1	1/1	1/1	N/A	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	33% 4/12	0/3	0/1	0/1	2/2	0/1	2/2	0/1	N/A	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a through c. Overall, ISPs reviewed needed improvement with regard to ensuring that individuals who would benefit from alternative and AAC, EC devices, or language-based supports and services had ISPs that described how the individuals communicated, and included plans or strategies to meet their needs. Examples of concerns included the following:

- For three of nine individuals, their ISPs did not provide complete functional descriptions of their communication skills. For Individual #346, the ISP included only a very limited description of how others should communicate with him. For Individual #362, the ISP included some information about how others should communicate with him, but only limited information about how he communicated with others (e.g., he speaks and understands English and Spanish). For Individual #226, the ISP provided a few strategies for how to communicate with her, but no functional examples of how she communicated non-verbally with others.
- For two of seven individuals who required a Communication Dictionary, the IDT did not provide evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.
- For only two of seven applicable individuals did the ISP include communication strategies, interventions and programs recommended in the communication assessment.

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: Although all individuals had one or more SAPs, most individuals could have benefited from additional SAPs. To that end, the Center was working on improving the way IDTs generated ideas for topics/skills for SAPs. The QIDP Coordinator, the SAP manager, and the ADOP were working together on this project. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 7	389	95	68	16	358	257	390	142
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.	58% 11/19	2/2	0/2	1/3	2/2	0/2	0/1	3/3	1/2	2/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	16% 3/19	2/2	0/2	0/3	0/2	1/2	0/1	0/3	0/2	0/2

Comments:

1. 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 #7, Individual #389, Individual #68, Individual #16, Individual #390 and Individual #142, and one SAP for Individual #358 for a total of 19 SAPs for this review.

Likely, these individuals would have benefited from additional SAPs given their many skill deficits. The Center was actively working on improving its process for determining what topics/skills should have a SAP.

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 #389's sign watch TV SAP), or appeared to be compliance plans (e.g., Individual #390's count change SAP).

5. Individual #16's laundry SAP, and Individual #7's shred paper and make a sno-cone SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. The only way to ensure that data are reliable is to consistently conduct IOA on all SAPs at San Antonio SSLC.

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: It was good to see that for the first time, all three assessments were current for all individuals. There was also improvement in their availability to the IDT. Inclusion of recommendations for skill acquisition in vocational assessments remained at about two-thirds. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	78% 7/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	67% 6/9	1/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1

Comments:

11. Individual #68's vocational assessment and FSAs were late, and Individual #95's PSI was late.

12. Individual #390, Individual #358, and Individual #16's vocational assessments did not have recommendations for SAPs, or a rationale for why vocational SAPs were not necessary.

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, 33 of these indicators were in the category of requiring less oversight. For this review, nine other indicators were added to this category, in restraint, psychiatry, and pharmacy. The behavioral health/psychology indicators were moved to an exited status. Thus, there are now 26 indicators in the category of requiring less oversight and 17 indicators that have been exited.

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 and new ADOP. One unit director was new since the last review and there was a vacancy for one of the director positions. Even so, the current group was knowledgeable about their units, facility operations, and staffing needs. Morning unit meetings contained a lot of relevant information about the past day and the upcoming day.

Goals/Objectives and Review of Progress

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In addition, integrated progress reports with data and analysis of the data 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, once the department establishes goals regarding psychiatric indicators for increase and decrease and routinely obtains reliable data for psychiatric indicators, then the Monitoring Team can assess progress.

Acute Illnesses/Occurrences

For restraint occurrences of more than three in a rolling 30-day period, all criteria for all indicators were met.

Psychiatry staff took action to address individual's psychiatric symptoms if there was deterioration or increase in symptoms.

Overall, the quality of medical practitioners' assessment of and follow-up on acute issues treated at the Center as well as those requiring out-of-Center treatment did not meet generally accepted standards of care, and for some individuals reviewed, significant concerns were noted. For at least the past six reviews, the Center has shown poor compliance with these requirements. During this review, regression was noted even with requirements on which the Center had previously done well.

In fact, due to declining conformance, the one indicator in less oversight related to communication between Center and hospital staff is in jeopardy of returning to active oversight. As indicated in previous reports, the Center needs to prioritize improvements in these areas. It is unclear to the Monitors why an emphasis has not been placed on improving medical care at the Center.

For the three acute events reviewed, nurses only sometimes followed relevant guidelines with regard to the completion of necessary initial assessments. Improvements also are needed with regard to the completion of acute care plans when needed, the quality of acute care plans, and nurses' implementation and/or documentation of the completion of the assessments and other interventions.

As part of the onsite review week, the Monitoring Team appreciated the Program Compliance Nurse, as well as the Chief Nurse Executive (CNE), and the Nursing Operation Officer's willingness to conduct an objective review of one acute care plan for one of the individuals reviewed, and discuss their findings openly with the members of the Monitoring Team and State Office staff. The Program Compliance Nurse did a nice job presenting the findings of the Center's review to the group. This effort showed Center staff's ability to identify strengths, as well as weaknesses in the acute care plans and the related nursing assessments, as well as to identify potential solutions to the significant improvements that are needed. The Monitoring Team is hopeful that such audits will continue and result in constructive feedback to nurses, and that at the time of the next review improvements will have occurred in the quality of the acute care plans and their implementation.

As a result of problems with emergency dental care for an individual reviewed, indicators that have been in less oversight are at risk of returning to active oversight, if issues are not corrected.

Implementation of Plans

Psychiatry and behavioral health services worked very well together at San Antonio SSLC. This was evident in the documentation and in many comments from many different staff at the Center. Better documentation of the psychiatrist's involvement in the development of the PBSP remained needed. Psychiatry and neurology collaboration remained very good and so did the documentation.

In psychiatry, there was regular conduct and completion of the quarterly reviews. The fourth quarterly could also serve as the annual, with some minor modifications. There were some components of the documentation of the quarterly reviews, however, that were missing or needed improvement.

Psychiatry clinic for both psychiatrists were observed. 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.

In behavioral health services, half of the nine individuals who had good reliable data were also making progress. Of the five individuals who were not rated as making progress, three also met criteria for all of the other indicators in behavioral health.

Thus, these individuals, although not making progress, was deemed to be receiving psychology/behavioral services and supports as per the monitoring tool. In other words, seven of nine individuals were deemed to be receiving psychology/ behavioral services and supports as per the monitoring tool. Moreover, for the other two, the missing aspects were some components of the PBSP for one, and poor graphs for the other.

All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.

The current PBSP data collection system was adequate, however, its sensitivity could be further enhanced by adding frequency within intervals when possible/practical. The graphs are useful for making data based treatment decisions.

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

For a number of individuals' chronic or at-risk conditions, PCPs working with IDTs had not conducted medical assessments, tests, and evaluations consistent with current standards of care, and had not identified the necessary treatment(s), interventions, and strategies, as appropriate. Moreover, IHCPs often did not include a full set of action steps to address individuals' medical needs.

It was good to see continued improvement with regard to PCPs' review and follow-up on non-facility consultations. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the findings and recommendations, and document their decisions and plans in ISPAs.

Overall, the Center made progress with regard to the provision of dental treatment, but needed to focus on the provision of fluoride treatments for individuals with medium or high caries risk.

Based on the individuals reviewed, practitioners reviewed Quarterly Drug Regimen Reviews (QDRRs) timely. As a result, the related indicator will be placed in the category requiring less oversight. Improvement is needed with regard to the quality of the QDRRs, and particularly the inclusion of recommendations related to irregularities in lab results that potentially implicate medications. In addition, prescribers need to implement agreed-upon recommendations.

Proper fit of wheelchairs was often still an issue.

Based on observations, there were still numerous instances (45% of 40 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. Problems were noted with regard to transfers, dining plan implementation, and positioning. Often, the errors that occurred (e.g., staff not intervening when individuals ate at an unsafe rate, staff not setting up transfers correctly, and staff not repositioning individuals) placed individuals at significant risk of harm.

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: Given sustained high performance, this indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	95								
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	(No longer scored)										
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										

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.	
27	The crisis intervention plan was complete.	
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	
Comments:		

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary:			Individuals:								
#	Indicator	Overall Score									
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.										
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.										
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: Once San Antonio SSLC establishes goals regarding psychiatric indicators for increase and decrease and routinely obtains reliable data for psychiatric indicators, then the Monitoring Team can assess indicators 8 and 9. Similarly, indicators 10 and 11 can then also be assessed. That being said, the Monitoring Team acknowledges the efforts of the psychiatry staff in taking action to	Individuals:

address individual's psychiatric symptoms. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	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	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	1/1	1/1		1/1	1/1

Comments:
8. To receive a positive score, indicators 4, 5, and 7 must be met, and the individual must have either met the goal, show progress, or maintain stability. Each of the two types of goals are scored separately in the individual scoring boxes above, and both must be met to receive an overall positive score for this indicator.

The individuals in the review group did not have psychiatry specific goals regarding the indicators for increase or decrease. As such, it was not possible to determine if an individual was making progress toward goals and/or maintaining stability.

9. Because there were no individuals with psychiatric goals documented or included in the IHCP, goals could not be updated in that document

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. The exception to this was Individual #257. Although there were no psychiatric goals available to objectively determine progress, the psychiatric clinical providers indicated that he was considered to be stable from a psychiatric perspective, and as such, had not required revisions to his overall treatment plan.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Psychiatry and behavioral health services worked very well together at San Antonio SSLC. This was evident in the documentation (indicator 23) and in many comments from many different staff at the Center. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. Better documentation of the psychiatrist's involvement in the development of the PBSP remained needed. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	7	389	95	68	16	358	257	390	142

		Score									
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	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.	33% 3/9	1/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments:
23. The psychiatric documentation referenced the behavioral health target behaviors and the functional behavioral assessment reviewed the role of the psychiatric disorder upon the presentation of the target behaviors in all examples included in the review group.

24. This was not specifically documented for any individuals in the review group. The documentation regarding Individual #7, Individual #95, and Individual #358 included documentation of discussions between the psychiatrist and the IDT regarding the PBSP. As such, a 1 was scored.

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: Psychiatry and neurology collaboration remained very good and so did the documentation. With sustained high performance, this set of indicators might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 7	389	95	68	16	358	257	390	142
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 2/2	1/1								1/1
26	Frequency was at least annual.	100% 2/2	1/1								1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 2/2	1/1								1/1

Comments:
25-27. These indicators applied to two individuals in the review group, Individual #7 and Individual #142.

Per discussions with the psychiatry clinical staff, the indication for the anti-epileptic medication, Tegretol, prescribed to Individual #7 had been changed to seizure-only in March 2019. As Individual #7 did have documentation of a dual-purpose medication for part of the review period, the example was scored. The decision to remove the psychiatric indication from Tegretol was questionable because Tegretol is frequently prescribed to individuals diagnosed with Bipolar Mood Disorder as a mood stabilizer. Individual #7 had a diagnosis of Bipolar Mood Disorder. In addition, given the significant interactions between Tegretol and Individual #7's prescribed

psychotropic medication, Luvox, close coordination of care would be necessary. Individual #7 had experienced a negative interaction due to these two medications, specifically an elevation in the Tegretol level requiring dosage adjustments.

Although Individual #16 and Individual #389 were diagnosed with seizure disorder, there was documentation that the prescribed anti-epileptic medications were not being utilized for a dual purpose. In the example regarding Individual #16, this was questionable because the prescribed anti-epileptic medication, Trileptal, is frequently utilized to treat symptoms associated with Intermittent Explosive Disorder

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

Summary: Due to the sustained high performance regarding the regular conduct and completion of the quarterly reviews, and the quality of the psychiatry clinic sessions, indicators 33 and 35 will be moved to the category of requiring less oversight. There were some components of the documentation of the quarterly reviews, however, that were missing or needed improvement. Indicator 34 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 7	389	95	68	16	358	257	390	142
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 3/3			1/1					1/1	1/1

Comments:

33. Quarterly reviews were completed in a timely manner for all individuals requiring them.

34. The Monitoring Team looks for nine components of the quarterly review. None of the examples included all the necessary components. The reviews were missing from two to four elements. The most common missing elements were the psychiatric diagnosis with a description of the symptoms that support the diagnosis and whether the nonpharmacological interventions recommended by the psychiatrist and approved by the IDT were being implemented.

35. During the monitoring visit, psychiatry clinic was observed for three individuals in the review group. In addition, clinical encounters were observed for five individuals who were not included in the review group. Overall, the clinical encounters were thorough and included presentations of data. These data were regarding behavioral health target behaviors that in many cases were identical to the psychiatric indicators. As such, medications decisions were made utilizing available data.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.												
Summary: These side effect monitoring procedures were completed and reviewed timely for about half of the individuals. This was a nice improvement from 0% scores the last three reviews. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	56% 5/9	1/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1
Comments: 36. These assessments were correctly and timely completed for about half of the individuals. For the others, there were issues with both the timely completion and prescriber review of MOSES and AIMS/DISCUS assessments. For example, regarding Individual #142, the AIMS dated 5/2/19 was not reviewed until 5/23/19. In another example, regarding Individual #390, the prescribed did not review the assessments dated 1/2/19. In an example regarding Individual #16, there was a delay in completion of the AIMS assessment. An AIMS assessment was performed in January 2019 with the subsequent assessment performed in May 2019. There should have been an assessment performed in April 2019.												

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.												
Summary:			Individuals:									
#	Indicator	Overall Score									
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?										
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?										
Comments:												

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.												
Summary: These indicators continued to be met and have been for many consecutive reviews. Therefore, all four indicators will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A									
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: There was a need for improvement with regard to reviewing the psychotropic medication regimens and documenting the rationale for the regimens. That being said, there was a tapering plan/rationale for all individuals and all individuals were reviewed by polypharmacy committee. Given sustained high performance on indicator 45, that indicator will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	33% 1/3			0/1		0/1			1/1	
45	There is a tapering plan, or rationale for why not.	100% 3/3			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.	100% 3/3			1/1		1/1			1/1	

Comments:

44. These indicators applied to three individuals. Polypharmacy justification was appropriately documented in one example. There was a need for improvement with regard to reviewing the psychotropic medication regimens and documenting the rationale for the regimens.

45. There was documentation for individuals who met criteria for polypharmacy showing a plan to taper various psychotropic medications or documentation as to why this was not being considered in all examples meeting criteria for polypharmacy.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for all of the

individuals meeting criteria for polypharmacy. The polypharmacy committee meeting was observed during the monitoring 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 had made 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: Four of the nine 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 #16, Individual #257, Individual #390, Individual #142).

Of the five individuals who were not rated as making progress, three (Individual #7, Individual #95, Individual #68), 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, these individuals, although not making progress, was deemed to be receiving psychology/behavioral services and supports as per the monitoring tool. In other words, seven of nine individuals were deemed to be receiving psychology/ behavioral services and supports as per the monitoring tool. Moreover, for the other two, the missing aspects were some components of the PBSP for one, and poor graphs for the other.

Some goals were met in the last few months, but weren't yet updated, resulting in the low indicator 7 scores. When no progress, actions were identified/suggested. This was the case for all individuals for this review and for two of the last three reviews.

Individuals:

#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
6	The individual is making expected progress	44% 4/9	0/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/3		0/1	0/1		0/1				

8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 5/5	1/1	1/1	1/1	1/1		1/1			
9	Activity and/or revisions to treatment were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
6. Individual #142, Individual #390, Individual #257, and Individual #16's PBSP data indicated that they were progressing or maintaining low rates of target behaviors.

7. Individual #16's unauthorized departures objective was achieved in May 2019, however, it was not updated. Similarly, Individual #95's inappropriate sexual behavior objective was achieved in March 2019 and Individual #389's skin picking objective was achieved in May 2019, however, neither objective was updated.

8. All individuals that were not progressing had actions to address the lack of progress. This represents another improvement from last year when 50% of individuals not progressing had corrective actions documented.

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

Summary: The Center showed sustained high performance and a sustainable plan to continue to do so regarding staff training.

			Individuals:								
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
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: The Center showed sustained high performance and a sustainable plan to continue to do so regarding graphing.

			Individuals:								
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
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.	83%	1/1	0/1	1/1	1/1	1/1	1/1			

		5/6									
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.										
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.										

Comments:
20. The scale of Individual #389's graph did not lend itself to clear interpretation of his PBSP data.

Outcome 8 – Data are collected correctly and reliably.											
Summary: High performance was sustained since the last review.			Individuals:								
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
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 measures his/her replacement behaviors across all treatment sites.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
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).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
30	If the individual has a PBSP, goal frequencies and levels are achieved.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			

Comments:
26-27. The data collection system for target and replacement behaviors, was individualized, and flexible. Some data collection systems consisted of scoring occurrence per interval rather than frequency per interval. It is recommended that those systems change to a frequency per interval system in the future to improve the sensitivity of the data system.

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

30. Goal frequencies and levels were achieved for five of the six individuals. The exception was Individual #16's treatment integrity frequency over the last six months which, did not achieve the facility's frequency objective. This represents another substantial

improvement from the last review when 33% of individuals met their goal frequencies and levels of IOA, data collection timeliness, and treatment integrity.

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 goals/objectives related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 7	389	346	400	215	357	255	362	226
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/16	0/2	0/1	0/2	0/1	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/16	0/2	0/1	0/2	0/1	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/16	0/2	0/1	0/2	0/1	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/16	0/2	0/1	0/2	0/1	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/16	0/2	0/1	0/2	0/1	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #7 – constipation/bowel obstruction, and seizures; Individual #389 – osteoporosis, and seizures; Individual #346 – other: hypertension, and diabetes; Individual #400 – other: Vitamin D deficiency, and constipation/bowel obstruction; Individual #215 – cardiac disease, and UTIs; Individual #357 – diabetes, and neurological; Individual #255 – cardiac disease, and constipation/bowel obstructions; Individual #362 – other: tobacco use disorder, and cardiac disease; and Individual #226 – diabetes, and aspiration/respiratory compromise).

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 #389 – seizures (i.e., his seizure disorder was managed through medication, so a goal designed for him to take steps to improve his health was not needed), and Individual #400 – constipation/bowel obstruction (i.e., controlled with medication). None of the remaining goals/objectives were clinically relevant, and/or measurable.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports on these goals with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring,

that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.

Summary: Four of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, Center staff need to focus on ensuring preventative care is provided as needed. These indicators will continue in active oversight until improvements occur, and the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, additional improvements are needed with regard to prescribers reviewing and addressing, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

#	Indicator	Overall Score	Individuals: 7	389	346	400	215	357	255	362	226
a.	Individual receives timely preventative care:										
	i. Immunizations	67% 6/9	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	75% 3/4	1/1	N/A	N/A	N/A	N/A	N/A	1/1	1/1	0/1
	iii. Breast cancer screening	0% 0/2	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	57% 4/7	0/1	1/1	1/1	N/A	1/1	0/1	1/1	N/A	0/1
	vii. Cervical cancer screening	100% 3/3	1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	56% 5/9	1/1	1/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1

Comments: a. The following problems were noted:

- For individual #7:
  - In the official immunization records, no documentation was found of her varicella status.
  - The Center did not submit a mammogram report.
  - A note indicated that on 11/9/18, an attempt to complete a DEXA scan was unsuccessful. However, the records did not include documentation of another attempt.
- No documentation was found for Individual #389's varicella status in the official immunization records.
- Individual #346's hearing screening indicated: "did not pass the pure tone threshold hearing screen… He will be referred for an Audiological assessment." Center staff did not submit such an assessment.
- Of note, for Individual #215, the IDT/LAR discontinued colorectal cancer screening based on the diagnosis of severe aortic stenosis. However, as discussed elsewhere in this report, this diagnosis might not be accurate.
- For Individual #357:
  - No documentation was found to show that she received the pneumonia vaccine.
  - On 3/14/19, she was uncooperative with a DEXA scan, but the records did not include documentation of another attempt.
- For Individual #226:
  - On 12/18/18, a computed tomography (CT) DEXA scan showed a T-score of -2.5 consistent with borderline osteoporosis. The AMA did not include a calculation of a FRAX score to determine if additional therapy was indicated, and treatment was limited to calcium and vitamin D for this individual who received long term-treatment with Phenobarbital.
  - Center staff submitted no evidence of colorectal cancer screening. The AMA stated that during an ISPA meeting in June 2017, the IDT decided to complete no further fecal immunochemical tests (FIT) or colonoscopy due to surgical bleeding risk due to the use of Lovenox and high respiratory complication. It should be noted that the use of Lovenox is not an absolute contraindication to performing a colonoscopy, when indicated.
  - No mammogram report was submitted. The AMA stated that on 11/20/18, one could not be completed, but there was no evidence that a mammogram had ever been performed.

b. Additional improvements are needed with regard to prescribers reviewing and addressing, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. For example, at times, PCPs indicated that individuals were not at risk for metabolic syndrome, when the individuals clearly were at risk.

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	7	389	346	400	215	357	255	362	226
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State	N/A									

	Office Guidelines.										
Comments: a. N/A											

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 as well as those requiring out-of-Center treatment did not meet generally accepted standards of care, and for some individuals reviewed, significant concerns were noted. For at least the past six reviews, the Center has shown poor compliance with these requirements. During this review, regression was noted even with requirements on which the Center had previously done well. In fact, due to declining conformance, the one indicator in less oversight related to communication between Center and hospital staff is in jeopardy of returning to active oversight. As indicated in previous reports, the Center needs to prioritize improvements in these areas. It is unclear to the Monitors why an emphasis has not been placed on improving medical care at the Center. The remaining indicators will continue in active oversight.			Individuals:							
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	0% 0/8	0/2	0/1	0/1	N/A	0/1	N/A	0/1	0/2	N/A
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	13% 1/13	0/2	0/1	1/1		0/1		0/1	0/2	
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	17% 1/6	0/1	0/1	N/A	N/A	0/1	N/A	0/1	N/A	1/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	0% 0/3	0/1	N/A	N/A		N/A		0/1		0/1

e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	33% 2/6	0/1	0/1	N/A		1/1		1/1		0/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance, 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.	60% 3/5	N/A	N/A	1/1		1/1		1/1		0/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	29% 2/7	0/1	0/1	0/1		1/1		0/1		1/2

Comments: a. For six of the nine individuals reviewed, the Monitoring Team reviewed eight acute illnesses addressed at the Center, including: Individual #7 (finger fracture on 1/4/19, and seizures on 6/5/19), Individual #389 (conjunctivitis on 4/26/19), Individual #346 (upper respiratory infection on 1/29/19), Individual #215 (gastric burn on 1/20/19), Individual #255 (elbow trauma on 7/8/19), and Individual #362 (hematochezia on 1/12/19, and choking on 2/20/19).

Based on documentation submitted, PCPs assessed none of the acute issues treated at the Center according to accepted clinical practice.

b. For Individual #346 (upper respiratory infection on 1/29/19), the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized.

The following provide examples of concerns noted:

- On 1/14/19, at around 4:00 p.m., nursing staff documented that Individual #7 had a swollen left 5th finger. There was no documentation of a medical evaluation, but an x-ray was ordered. At approximately 9:04 p.m., nursing staff notified the on-call MD, and requested that the individual be placed on "MD follow-up for tomorrow morning and immediate consult to Dr. [orthopedist]."

  On 1/15/19, the PCP evaluated the individual and noted that the finger had minimal bruising with no swelling. The x-ray revealed a comminuted fracture of the left distal phalanx. The assessment was "finger trauma," and the plan was to arrange to send to the individual to orthopedics. The PCP indicated that follow-up would occur as clinically indicated.

  The orthopedist saw the individual, and documented that normally the injury required one week of some protection, but the individual refused splinting in the office. Therefore, she was discharged from the office with follow-up in orthopedics as needed. The PCP conducted no further follow-up to determine if healing occurred as expected.
- On 6/5/19, nursing staff documented that Individual #7 had a three-minute seizure while at the Developmental Center (DC). Nursing staff administered intramuscular (IM) Ativan, and notified the PCP. The seizure was believed to be related to a drug interaction between fluvoxamine and carbamazepine that resulted in an increase in the carbamazepine level. While the ADR

form documented that the PCP made a change in the dose of the carbamazepine, the records reviewed did not document that the PCP conduced any clinical assessment of the individual related to the seizure or the adverse drug reaction.

- On 5/6/19, the PCP documented seeing Individual #389 for completion of antibiotics. The PCP documented that on 5/3/19, the individual finished eye drops for treatment of conjunctivitis, starting on 4/26/19. The exam was "eyes clear." In the documents submitted, the PCP had not documented a previous medical assessment related to a diagnosis of conjunctivitis. Of note, the PCP did not mention the healing chin laceration from 4/29/19.

  In its comments on the draft report, the State disputed this finding, and stated: "PCP documented in IPN (04/26/19 at 16:51) that individual 389 had evaluation where was diagnosed with conjunctivitis and ordered antibiotic gtts OU TID x7 days." During and after the onsite review, Center staff acknowledged problems with the IPN submissions and submitted corrected versions, including a version that purportedly included all medical IPNs. After checking the two versions of the corrected IPNs, the Monitoring Team was unable to find a medical IPN, dated 4/26/19. It is unclear to what the State was referring.
- On 1/29/19, nursing staff reported that Individual #346 complained of a sore throat and generalized pain. Nursing staff gave him ibuprofen. The individual asked to see the PCP. He also requested his allergy medication, but refused to allow the nurse to take his blood pressure, so nurse did not administer the pro re nata (PRN, or "as needed") allergy medication.

  Per a late entry nursing IPN, dated 1/30/19, the individual dropped to the floor in the living room as he was walking to the couch. He then began to complain of pain in his right ankle. Per nursing notes, at 8:15 a.m., the PCP assessed him. (The assumption was that this occurred on 1/29/19, but the PCP did not write anything,) The PCP did not document an assessment in the IPNs related to the initial evaluation. However, per nursing documentation in the late entry on 1/30/19, labs, a flu swab, and ankle x-ray were completed, and a provider prescribed Cepacol lozenges.

  On 1/31/19, the PCP documented that the individual appeared to feel better, but still complained of a sore throat and ankle pain. The PCP documented the physical exam as normal. The chest x-ray and ankle x-rays were normal. The assessment was "resolving URI." The plan was for nursing staff to monitor him.

  In its comments on the draft report, the State disputed the finding with regard to Indicator 6.b (i.e., follow-up on an acute issue) for this individual. It was unclear why the State disputed the score of "1." The State's comment read: "IPN PCP documentation submitted supports that the pharyngitis and ankle pain were addressed on 1/29/19 10:11 CST, 1/30/19 08:50 CST & 1/31/19 08:58 CST. Foot pain was not made known until 1/30/19, post fall and x rays ordered." [sic] 'Not walking with limp,'and [sic] x ray ankle and chest were negative. 'Constitutional: No fever, chills or night sweat. Respiratory: + cough no wheezing. Musculoskeletal: ankle pain without swelling.' Also addendum 2/1/19 3:42 pm CST Viral titers were negative." If the State was disputing the score for the assessment portion of the finding (i.e., Indicator 6.a), the revised medical IPNs submitted to the Monitoring Team included a note, dated 1/31/19, at 8:58 a.m. There was no documentation of a timely assessment on 1/29/19, or 1/30/19. The score of 0 was based on this information.
- On 1/20/19, nursing staff documented that Individual #215 "has a gastric burn to his left upper arm." The area of involvement was 17 centimeters (cm) by 14 cm with depth undetermined. Nursing staff determined that the gastric contents burned the individual's arm, and notified the PCP. The PCP gave an order to clean the area with soap and water. Nursing staff subsequently documented open areas with redness, bloody drainage, and swelling. Nursing notes also indicated that the

individual moaned when the area was touched "as if in discomfort." On 1/23/19, redness was reported as slightly increased with serosanguinous drainage.

On 1/23/19, the PCP evaluated the individual. The assessment was a second degree burn of the left elbow. The plan was to apply Silvadene creme for 14 days with occlusive dressing, and nursing staff were to monitor for a secondary infection. On 2/6/19, the PCP conducted follow-up and noted that the burn was healing well and treatment would be extended for seven days. The PCP did not conduct further follow-up for this problem, and did not document resolution. On 2/28/19, nursing staff documented that there were open red areas near the elbow in the same area of the burn.

- On 7/8/19, nursing staff reported that Individual #255 had swelling to the left elbow: "This nurse noted warmth and swelling to L elbow, which looks like a little ball at elbow site." The PCP ordered x-rays of the elbow. On 7/9/19, at around 5:00 a.m., nursing staff documented reading the results to the PCP, and indicated that no new orders were forthcoming at this time: "Results as follows: Moderate -severe soft tissue swelling dorsally. Anterior joint effusion. Mid arthrosis, normal mineralization, no dislocations." This was an abnormal x-ray. However, there was no documentation to show a medical provider completed an evaluation. It was unclear how the joint effusion and swelling were managed, since there was no medical assessment documented. Nursing staff documented that the on-call PCP considered the diagnosis of an olecranon bursitis when ordering the x-ray. Given the nursing findings of swelling and warmth and the x-ray findings of a joint effusion, a PCP should have immediately examined this individual.
- On 1/12/19, at around 6:30 p.m., nursing staff documented that Individual #362 "went to bathroom and had a large BM [bowel movement] come [sic] to nurse because he had blood in the toilet noted a very large brown stool notified ODRN [on-duty Registered Nurse], came to home assessed consumer noted he has hemorrhoids. No blood noted around his rectum at this time."

  Nursing staff documented notifying the on-call PCP and that the PCP would follow up the following day. There was no documentation of a medical assessment. In fact, there was no documentation of any medical assessments in the 205 pages of IPNs submitted, despite the Monitoring Team's repeated requests to ensure that Center staff submitted all PCP documentation.
- On 1/12/19, Individual #362's family reported that he choked on a piece of hamburger while at home and required abdominal thrusts. Upon his return to the Center, nursing staff assessed him, but the PCP did not see him.

  On 2/20/19, nursing staff documented that the individual had a choking episode, during which he was observed without respirations or cough. Abdominal thrusts relieved the obstruction, and according to nursing staff, the individual appeared to be in no distress. Nursing staff notified the PCP, and documented "no orders received." A medical provider did not assess the individual.

  This individual experienced two choking incidents within a two-month period. He did not have a history of dysphagia and had a regular diet texture. There was no documentation of a medical assessment in the IPNs submitted. The PCP should have evaluated the individual to determine if diagnostics, such as a modified barium swallow study (MBSS) were indicated. Without a medical assessment, the medical plan of care was not clear.

c. For six of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses/occurrences that required

hospitalization or an ED visit, including those for Individual #7 (ankle injury on 4/16/19), Individual #389 (laceration on 4/29/19), Individual #346 (seizures on 4/21/19), Individual #215 (atrial fibrillation and influenza on 2/8/19), Individual #255 (PEG replacement on 6/24/19), and Individual #226 (sepsis on 5/17/19, and pneumonia on 6/13/19).

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

- On 4/16/19, at approximately 1:43 p.m., nursing staff notified the PCP that Individual #7 had possibly injured her right ankle and had noticeable swelling. There was no documentation of a medical evaluation, but an x-ray was ordered and was completed at around 5:00 p.m. Nursing staff documented the following x-ray report: "Suggestion of a fracture of the lateral malleolus below level of ankle joint of unknown age seen on one view, medial malleolus appear intact." At approximately 8:10 p.m., nursing staff notified the on-call PCP who ordered application of an ace wrap and use a wheelchair until the PCP could conduct a review.

  On 4/17/19, the individual was scheduled for a colonoscopy. Prior to the individual leaving for the colonoscopy, there was no documentation to indicate that a medical provider examined the individual to determine the extent of the injury, stability of the ankle, and the neurovascular status of the extremity. According to nursing documentation, the individual was sent to the ED after the colonoscopy for an x-ray of the right ankle before returning to the center. Documentation was not submitted to show that Center staff communicated with hospital staff. Center staff did not submit ED records.

  On 4/18/19, the on-call PCP wrote a note stating that he was notified of the abnormal x-ray on 4/16/19 and possible fracture, and the PCP saw the individual and ordered ice packs and repeat films after the GI consultation at hospital. The repeat films were negative for a fracture and the plan was to resume normal activities.

  The records reviewed did not provide any documentation that a medical provider conducted an evaluation to substantiate a diagnosis or support a plan that the individual should resume normal activities. Nursing staff provided the only ongoing documentation, which noted swelling and an abrasion, and at times, included the diagnosis of ankle sprain.
- Per nursing documentation, on 4/29/19, at around 8:33 a.m., Individual #389 was transferred to the ED for repair of a facial laceration. Documentation was not submitted to show that Center staff communicated with hospital staff. At approximately 11:49 a.m., the individual returned to the Center, with the laceration repaired with Dermabond. Reportedly, a CT scan of the head was negative. Based on the IPNs submitted, a medical provider did not document information related to the injury, the evaluation in the ED, or follow-up after return from the ED. The Center did not submit the ED records as requested.
- On 4/21/19, while at home with his family, Individual #346 experienced a seizure, and was taken to the ED for evaluation. At approximately 7:30 p.m., he returned to the Center.

  On 4/22/19, the PCP saw him, and noted no work-up was done in the ED, but he was loaded with intravenous (IV) Keppra. The PCP did not provide any plan, other than ordering an EEG. Based on the documentation submitted, no additional follow-up occurred in relation to this ED visit for a seizure in an individual who appeared to have a new onset seizure disorder.

  According to a PCP IPN, dated 5/21/19, the individual was seen in the epileptology clinic, and the individual was diagnosed with "seizure disorder (tonic-clonic), newly diagnosed."

- On 2/6/19, nursing staff notified the on-call PCP that Individual #215 had a fever. The PCP ordered a rapid flu swab, which returned positive for influenza. The individual was started on Tamiflu, placed in isolation, and given Tylenol for fever.

  On 2/7/19, the PCP assessed the individual and noted that he did well overnight, except for occasional wheezing. The physical exam was unremarkable. The plan was to continue supportive care.

  At 10:13 p.m., nursing staff documented that the individual's oxygen (O2) saturation decreased to 92%, wheezing was heard bilaterally, and accessory muscles were being used to breathe. Nursing staff administered oxygen, and notified the PCP. The PCP ordered a chest x-ray.

  On 2/8/19, at 12:58 a.m., the individual was transferred to the ED due to deterioration of status, including a blood pressure of 86/63, pulse 150, and O2 saturations of 93 to 94 on 2 liters (l) by nasal canula. He was admitted to the Intensive Care Unit (ICU) with the diagnoses of influenza, possible pneumonia, and atrial fibrillation. This was an after-hours transfer, but the PCP did not enter an IPN within one business day. The individual required cardioversion for management of the atrial fibrillation.

  On 2/9/19, he returned to the Center. On 2/10/19, and 2/11/19, the PCP conducted follow-up.
- On 6/24/19, nursing staff documented that at 1:20 p.m., Individual #255's PCP ordered transfer to the ED for PEG-tube replacement due to leakage. There was no documentation of an assessment by a medical provider, and there was also no note written within one business day. He was admitted to the hospital, and on 6/26/19, he returned to the Center.

  On 6/27/19, the PCP saw him. The PCP noted that an esophagogastroduodenoscopy (EGD) was performed, and the PEG-tube was replaced. The PCP's plan stated: "Advised by SLP that additional pleasure feedings and additional fluid intake by mouth is not safe." However, it was difficult to determine if this meant no oral intake was to occur.

  The PCP completed and/or documented no additional follow-up related to this hospitalization. According to the post-hospital ISPA, under the dietary section, pleasure feedings would continue. In December 2018, the individual had been hospitalized with aspiration pneumonia, failed two MBSSs, and required the use of a trach, which was later reversed.
- On 5/16/19, the PCP documented an evaluation of Individual #226 for left arm bruising. She recently was started on low molecular weight heparin for a recent deep vein thrombosis (DVT). The PCP did not specify the location of the DVT. The plan was to reduce the dose of the heparin, and follow-up as clinically indicated.

  On 5/17/19, the individual had a pulse of 124 to 126, and a temporal temperature of 99.5 degrees Fahrenheit. The PCP ordered Tylenol for possible pain. Nursing staff did not indicate a potential source of pain.

  Later, on 5/17/19, the individual was grunting, flushed, and had a heart rate of 134, and a respiratory rate of 26. She was transferred to the ED for evaluation of a 103.3 axillary temperature. On 5/19/19, the PCP made an IPN entry indicating that the individual was admitted with a diagnosis of sepsis.

  When she was noted to be tachycardic on 5/17/19, this individual should have had a more accurate temperature measurement

taken. A temporal temperature is .3 to .6 degrees Celsius lower than an oral temperature. Tylenol likely masked a fever and developing sepsis.

On 5/24/19, Individual #226 was discharged. The PCP saw her, and documented that the individual was treated for sepsis initially in the ICU, after being admitted with a fever and tachycardia. The PCP documented in this note that the source of the infection and organism were unknown. The plan was to continue heparin, and follow-up the next day. The next day, another PCP saw the individual, and noted that the she was treated for E coli sepsis and was "doing well." The plan was to monitor. On 5/29/19, the IDT held a post-hospital ISPA meeting; the PCP did not attend, but should have.

In its comments on the draft report, the State disputed this finding and stated: "Per post-discharge ISPA (05/29/2019): 'PCP reported that [she] returned from hospital with oral antibiotics. Given that her hospitalization was for respiratory-related issues, she will be sent to pulmonology for evaluation although it is not clear if [she] has pneumonia. Her case will be reviewed by the Pneumonia Review Team to determine the nature of the event." The Monitoring Team re-reviewed the referenced ISPA, and again noted that the participants listed were a direct support professional, the QIDP, a nutritionist, a day program staff member, and a Recreation Therapy staff member. This was not a duly constituted team to discuss this significant hospitalization for sepsis. The PCP should have participated to assist the IDT in reviewing the related IHCPs, and making changes to the plans, as needed.

On 6/11/19, at 8:38 a.m., nursing staff documented that the individual had a pulse of 125, and respiratory rate of 28. Nursing staff administered Tylenol for possible pain. At 9:38 a.m., nursing staff reported that the individual was in no distress. At 8:51 p.m., a nurse notified the PCP that the individual had a fever, tachycardia, and increased respirations. The PCP ordered labs and a KUB (i.e., an abdominal x-ray). At around 9:56 p.m., the nurse notified the PCP that attempts to draw labs were not successful.

On 6/12/19, at 5:42 a.m., the KUB was completed. At approximately 10:46 a.m., labs were obtained. At 11:50 a.m., nursing staff documented the individual's respiratory rate was increased and expiratory wheezing was heard.

Per nursing staff: "At 1410, KUB result was read to MD. No new order noted at this time. The writer told MD that it is also written the result paper [sic] that the findings are worse than 6/6/2019 result... MD stated 'I will think about the result tomorrow.'"

On 6/13/19, at 4:43 p.m., the PCP made an IPN entry, which was identified as a Post-Hospital Evaluation Day1 Note. The PCP stated: "notified last evening of return of patient. I had discussed with hospitalist. She was felt to have pneumonia, comm-acquired vs aspiration." It further stated that she was stable since her return. However, there was no evidence that the individual was hospitalized the previous day. There was a very limited exam documented that stated: "awake and in no apparent distress, chest clear, heart rr." The note further noted that the individual's sodium was 126, and the KUB showed a possible ileus worse than before. The plan was to transfer to the hospital.

Per nursing documentation, on 6/13/19, at around 7:00 p.m., the individual was transferred to the ED for evaluation of hyponatremia and a positive result on the KUB.

The PCP's documentation related to this event was not clear. Nevertheless, there appeared to be a delay in obtaining the lab studies, a delay in the PCP assessing the individual, and a delay in the PCP acting upon the KUB findings, which nursing staff reported to the PCP the previous day (i.e., on 6/12/19).

On 6/18/19, the individual returned to the Center, and the PCP saw her. The assessment was pneumonia and the plan was to follow-up the next day. This post-hospital note provided no information on the hospitalization, diagnosis, treatment, or medical plan of care.

On 6/20/19, the PCP documented that the hospital record was in the shared drive, but again there was no information provided on the hospitalization. The assessment was "recovered from pneumonia," and the plan was: "Follow-up as indicated." Based on the documents submitted, the PCP conducted no additional follow-up.

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

Summary: It was good to see continued improvement with regard to PCPs' review and follow-up on non-facility consultations. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the findings and recommendations, and document their decisions and plans in ISPAs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 7	389	346	400	215	357	255	362	226
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	94% 15/16	2/2	2/2	2/2	1/1	2/2	2/2	2/2	1/1	1/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	75% 12/16	2/2	0/2	2/2	1/1	2/2	1/2	2/2	1/1	1/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	88% 14/16	1/2	2/2	2/2	1/1	2/2	2/2	2/2	1/1	1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 15/15	2/2	2/2	2/2	1/1	2/2	2/2	2/2	1/1	1/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	25% 1/4	1/1	N/A	0/1	N/A	N/A	0/1	0/1	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #7 for ear, nose, and throat (ENT) on 2/12/19, and neurology on 2/22/19; Individual #389 for ENT on 2/26/19, and pulmonology on 3/26/19; Individual #346 for orthopedics on 3/5/19, and neurology on 5/21/19; Individual #400 for

podiatry on 1/22/19; Individual #215 for cardiology on 5/20/19, and ophthalmology on 6/27/19; Individual #357 for ENT on 1/29/19, and ophthalmology on 2/7/19; Individual #255 for cardiology on 1/28/19, and cardiology on 3/11/19; Individual #362 for ophthalmology on 3/7/19; and Individual #226 for ENT on 2/12/19, and podiatry on 4/11/19.

a. For many of the consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations, and provided rationales for disagreements. The exception was the consultation report for Individual #226's podiatry consultation on 4/11/19, for which the documents included no IPN from the PCP.

b. The reviews that did not occur timely included those for Individual #389 for ENT on 2/26/19, and pulmonology on 3/26/19; Individual #357 for ophthalmology on 2/7/19; and Individual #226 for podiatry on 4/11/19.

c. Most of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exceptions were for Individual #7's ENT consultation on 2/12/19, for which the PCP did not document the significance of the results in the IPN; and Individual #226's podiatry consultation on 4/11/19, for which the documents included no IPN from the PCP.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, which was good to see.

e. The following problems were noted:

- For Individual #346's neurology appointment on 5/21/19, the PCP's summary stated that the electroencephalogram (EEG) confirmed the diagnosis of seizure disorder, which was "newly diagnosed." However, the PCP did not make a referral to the IDT. Given the significance of this new diagnosis, a referral was warranted. For example, the IDT would need to develop/revise the related IHCP(s).
- For Individual #357's ENT appointment on 1/29/19, the consultant recommended auditory response testing with magnetic resonance imaging (MRI) of the brain and internal auditory canal. The PCP noted uncertainty about agreement with the recommendation. Consultation with the IDT would have been appropriate. At the time of the review, the studies had not been completed.
- For Individual #255, the PCP did not make a referral to the IDT related to his cardiology appointment on 1/28/19. However, the PCP should have made the IDT aware of the individual's high risk for a stroke due to the lack of anticoagulation, and the decision to for him to remain in atrial fibrillation without ablation, because of the cardiologist's determination that he was stable. The IDT might have discussed alternative treatment options.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.	
Summary: For a number of individuals' chronic or at-risk conditions, PCPs had not completed medical assessments, tests, and evaluations consistent with current standards of care, and/or the PCPs had not identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.	Individuals:

#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
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	1/2	1/2	0/2	0/2	2/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., ., Individual #7 – constipation/bowel obstruction, and seizures; Individual #389 – osteoporosis, and seizures; Individual #346 – other: hypertension, and diabetes; Individual #400 – other: Vitamin D deficiency, and constipation/bowel obstruction; Individual #215 – cardiac disease, and UTIs; Individual #357 – diabetes, and neurological; Individual #255 – cardiac disease, and constipation/bowel obstructions; Individual #362 – other: tobacco use disorder, and cardiac disease; and Individual #226 – diabetes, and aspiration/respiratory compromise).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessments, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #346 – other: hypertension; Individual #400 – constipation/bowel obstruction; Individual #255 – cardiac disease, and constipation/bowel obstructions; and Individual #226 – aspiration/respiratory compromise. The following provide examples of concerns noted:

- Individual #7 was diagnosed with constipation for which she was prescribed PRN bisacodyl, daily polyethylene glycol, and sennosides. The AMA Assessment/Plan (A/P) stated: "constipation - functional and stable." The assessment should state the current status of the condition. Stability is a function of time and does not indicate overall control of a medical condition, which might be poorly controlled, but in fact stable over time. The AMA plan of care did not address the nonpharmacologic treatment of constipation. This was also not addressed in the two IMRs reviewed. The IMRs also did address the use of medication.
- According to the AMA, Individual #7 was diagnosed with a seizure disorder. The PCP documented the following assessment: "In the past year she has had 5 seizures and 4 seizures in 2011.... On 5/29/12, she saw neurology who stated that the previous CT of head and EEG were normal and advised to continue present medications."

  On 2/22/19, the individual was seen in the neurology clinic. Center staff submitted the consult IPN, but not the actual consult report. The neurologist recommended checking the individual's carbamazepine level and follow-up in one year.

  On 6/5/19, a nurse documented that the individual had a three-minute or more seizure while at the DC. IM Ativan was administered and the nurse notified the PCP. Based on the documents submitted, the PCP did not evaluate the individual.

  An ADR form was completed for this individual. The seizure was believed to be related to a drug interaction between fluvoxamine and carbamazepine that resulted in an increase in the carbamazepine level. While the ADR form documented that the PCP made a change in the dose of the carbamazepine, the records reviewed did not document that the PCP conducted any clinical assessment of the individual related to the seizure or the adverse drug reaction.
- Individual #389's AMA did not list osteoporosis as an active medical problem, even though Prolia was listed as a medication. Since it was not listed as an active problem, the PCP did not include a plan to address it.

  On 8/16/18, the last DEXA scan was competed and the individual received supplementation with calcium and vitamin D. The

assessment and plan should have documented osteoporosis as an active problem, and listed the current status and treatment. The PCP should have documented the plan for future diagnostics, such as the date of the next DEXA scan. The plan also should include precautions related to the use of Prolia.

- Per Individual #389's AMA, his seizure disorder was well controlled and a neurologist had seen him. The PCP had not documented the date of the individual's last seizure, or the date of the last neurology evaluation. The IMR, dated 6/30/19, documented a neurology evaluation, on 5/25/18, which recommended follow-up in one year. There was no consult submitted to reflect that follow-up had occurred.
- The AMA documented that Individual #346 had hypertension with evidence of hypertensive retinopathy. The PCP did not clearly identify the target blood pressure in the Assessment section, but noted that the individual was "doing well" with lisinopril. In addition to treatment with lisinopril, the individual was treated with propranolol for a psychiatric diagnosis. Propranolol is a beta blocker, which lowers blood pressure. IView documentation showed several blood pressure readings in which the systolic blood pressure was greater than 140. The exact age at which he was diagnosed was not clear, but there were several concerning issues, including:
    - He was diagnosed with hypertension at a very young age (i.e., less than 23, which was his current age);
    - His hypertension was not well controlled on two antihypertensive medications; and
    - He had evidence of target organ damage, indicating poor control of his hypertension.

  This individual should have further evaluation to determine if he has any additional target organ damage. Moreover, given that this young individual needs very meticulous control of his blood pressure, he might benefit from referral to a hypertension specialist.
- Individual #346 met the criteria for the diagnosis of metabolic syndrome. Per the QDRR, dated 7/1/19, his waist circumference was 55 inches, high-density lipoprotein (HDL) was 34, and lisinopril was prescribed for the treatment of hypertension. Additionally, on 4/4/19, the individual had a hemoglobin (Hg) A1c of 5.8, which was consistent with the diagnosis of prediabetes. These issues were not included in the active problems list (APL), and the PCP had not addressed them in the AMA or the IMRs reviewed.

  According to the AMA, the individual lost 20 pounds with diet and increased physical activity, and the goal was for him to weigh less than 300 pounds. The plan was to continue weight reduction and monitor weight quarterly. Given that the individual met the criteria for metabolic syndrome and prediabetes, additional supports might have been warranted. Consideration should have been given to starting pharmacological treatment for prediabetes.
- Individual #400's vitamin D deficiency was discussed under the osteoporosis section, which was rated at low risk. However, the IDT should consider the long-term use of the proton pump inhibitor (PPI), given that the Food and Drug Administration (FDA) has mandated revised safety information on all PPIs due to a possible increased risk of fractures of the hip, wrist, and spine. This increased risk combined with the diagnosis of vitamin D deficiency might warrant a higher risk rating. The individual was also treated with two second-generation antipsychotics (SGAs) that might result in increased prolactin levels that can increase the risk for osteoporosis.
- The PCP documented that Individual #215 had a diagnosis of severe aortic stenosis. Based on this diagnosis, palliative care was implemented and preventive care was discontinued. On 5/20/19, the cardiologist saw the individual, who noted that the atrial flutter was likely due to the acute illness of influenza. The consultation report also noted that the individual had mild to

moderate aortic stenosis and not severe aortic stenosis. The recommendations were to discontinue amiodarone, complete an electrocardiogram (EKG) in one to two weeks, and follow up in one month. On 6/17/19, the cardiologist wrote "aortic stenosis - no interventions. Stable cardiac continue current Tx [treatment]."

Aortic stenosis is a progressive disease with sequential stages defined according to anatomy, hemodynamics, and symptoms. The symptoms and management for mild to moderate aortic stenosis differ from those of severe aortic stenosis.

The PCP should review the cardiology consults and clarify the stage of aortic stenosis, as well as the cardiac prognosis for this individual. Discussing a DNR, to which the LAR did not agree, and termination of all preventive care, based on the diagnosis of aortic stenosis might not have been appropriate. Although other medical conditions might need to be taken into consideration, the individual did not appear to have severe aortic stenosis.

- Benign prostatic hyperplasia (BPH) was listed as an active medical problem for Individual #215, but the PCP did not include a medical plan of care to address it in the AMA. The individual required a suprapubic catheter and was at increased risk for urinary tract infections. This was not discussed in the IRRF.
- The PCP documented in the AMA that Individual #357 was overweight and a calorie-restricted diet was initiated with limited results. Other interventions to address weight loss were not discussed, such as increasing physical activity. Moreover, the IDT should have discussed the risks and benefits of the continued use of two SGAs in an individual who was gaining weight.
- Per the AMA, Individual #357 was seizure free on Trileptal. In November 2018, the neurologist saw her, and made no changes to the treatment plan. It was noted that she was not a candidate for an EEG due to behaviors. The plan was to follow-up in May 2019.

On 1/29/19, the PCP documented that the causes of multiple falls the individual experienced were a combination of hereditary gait abnormality, behavioral factors, necessary medication, and past injuries. The IDT requested a second neurology opinion. The PCP declined this request stating that the Center's neurology evaluation had been adequate.

Over the review period, this individual experienced numerous issues with balance and gait, and sustained a number of falls with numerous injuries (i.e., according to document #TX-SA-1908-II.P.1-20, the individual fell on the following dates: 1/3/19, 1/4/19, 1/6/19, 1/7/19 times two, 1/14/19 times eight, 1/21/19, 1/28/19, 2/2/19, 2/5/19, 2/8/19, 2/9/19, 2/10/19, 2/19/19, 2/25/19 times two, 3/7/19, 3/9/19, 3/22/19, 3/30/19, 4/17/19 times two, 4/27/19, 5/4/19, 5/8/19, 5/9/19, 5/19/19, 5/24/19, 5/31/19, 6/14/19, and 6/24/19 times two). The Center submitted only two PCP notes. One was related to an ISPA request for a second opinion. The other, dated 3/17/19, related to a self-injurious behavior (SIB)-related injury.

In the IMR, dated 6/30/19, the PCP did not address the individual's multiple falls, and apparently incorrectly documented the last neurology appointment was on 5/25/18. Per the AMA (done by another PCP), in November 2018, the neurologist also saw the individual. Moreover, in May 2019, the individual should have had a neurology consultation, but no report for that follow-up appointment was submitted.

The documentation reviewed did not support the PCP's statement that the Center's assessment of the multiple falls was thorough and sufficient to address the individual's needs. Given that the Monitoring Team reviewed this individual during the

last review, and identified concerns related to the lack of assessment around seizures/falls, this was concerning.

- Per the AMA, the PCP discussed tobacco cessation with Individual #362 and "he has no interest in no [sic] smoking." The PCP did not discuss what specific plan for tobacco cessation was discussed. The PCP also had not included the individual's smoking history (e.g., number of cigarettes smoked) in the AMA. The pack-per-year history was necessary to determine his preventive care screenings as he ages. The PCP should involve the IDT and Behavioral Health Services (BHS) in the discussion of smoking cessation. The individual was rated at high risk for cardiac disease, and the counselling related to tobacco cessation should be multidisciplinary.
- The PCP documented the following in the assessment section of Individual #362's AMA: "hypertriglyceridemia - previously atorvastatin was increased with no change in triglycerides. Cholesterol, HDL and LDL [low-density lipoprotein] are at good levels. His 10 year cardiovascular risk was 5.1%. He has been started on Fenofibrate and lipid panel will be checked in about 6 months." Although the management of hyperlipidemia was adequate, the overall cardiac risk did not address the individual's sedentary lifestyle and smoking.
- Per the assessment and plan in the AMA, Individual #226 was diagnosed with diabetic nephropathy and hypertension, and was stable. The plan was to continue enalapril to reduce the nephropathy risk and continue dosing and increasing the basal insulin dose to prevent hypoglycemic episodes. The goal was to maintain an A1c of less than 7.5.

  In early 2019, documentation showed problems with glucose control. The February 2019 QDRR noted that fast acting insulin was utilized on over 100 days of the review quarter indicating a need to adjust the basal insulin.

  The individual had developed sequelae of Type 2 diabetes mellitus (T2DM) in the form of nephropathy. It was important to ensure that other organ systems were not involved. The physical exam did not document an assessment of the individual's feet. In the overall assessment, the PCP also should have included that the eye exam was done and no evidence of diabetic retinopathy was noted.

  It was documented under preventive care that on 10/11/18, a diabetic foot exam was done. The podiatry evaluation completed on 4/11/19, lacked the elements required for a diabetic foot examination, such as the presence of pedal pulses and testing for protective sensation.

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

Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

#	Indicator	Overall Score	Individuals: 7	389	346	400	215	357	255	362	226
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of	0% 0/5	0/2	N/A	0/1	N/A	0/1	0/1	N/A	N/A	N/A

	the interventions.										
	Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, of concern, the action steps assigned to the PCPs often were not implemented.										

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	7	389	346	400	215	357	255	362	226
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
	Comments: a. and b. Due to problems with the production of documents related to Pharmacy's review of new orders, the parties have agreed that the Monitoring Team will not rate these indicators.										

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 PCP review of QDRRs reviewed during this review and the past two reviews (Round 13 – 94%, Round 14 – 100%, and Round 15 - 100%), as well as timely psychiatrist review (Round 13 – 83%, Round 14 – 100%, and Round 15 - 100%), Indicator c will move to the category requiring less oversight. Improvement is needed with regard to the quality of the QDRRs, and particularly the inclusion of recommendations related to irregularities in lab results that potentially implicate medications. In addition, prescribers need to implement agreed-upon recommendations.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
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;	28% 5/18	2/2	0/2	1/2	1/2	0/2	1/2	0/2	0/2	0/2
	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	71% 10/14	2/2	N/A	0/2	2/2	N/A	2/2	2/2	2/2	0/2
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	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% 14/14	2/2	2/2	2/2	2/2	N/A	2/2	2/2	2/2	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	63% 5/8	0/2	N/A	N/A	2/2	N/A	0/1	1/1	1/1	1/1
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. The Clinical Pharmacist is new to the Center. The QDRRs had a consistent pattern of highlighting abnormalities, but failing to elaborate on the potential etiologies. For example, it was not adequate to simply note that an individual had an anemia. The Clinical Pharmacist should comment on potential medication issues, and also recommend that the PCP conduct further evaluation of the anemia. If the anemia has been evaluated, then the Clinical Pharmacist should document the outcome of such as evaluation, such as that it was determined to be iron deficiency anemia or anemia of chronic disease, etc.

For two individuals with metabolic syndrome or at risk for metabolic syndrome, the Clinical Pharmacist did not identify the risk or diagnosis.

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

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was sometimes not presented to show they implemented them.

e. Due to problems with the production of documents related to Pharmacy's review of new orders, the parties have agreed that the Monitoring Team will not rate this indicator.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.

Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 7	389	346	400	215	357	255	362	226
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1

Comments: a. and b. One individual (i.e., Individual #255) was edentulous and noted to have low dental risk. The remaining eight individuals reviewed all had a high or medium dental risk rating, and therefore, should have had goals. None of these eight had clinically relevant, achievable, and measurable goals/objectives related to dental care.

The Monitoring Team worked with State Office on this issue so that State Office could provide more guidance to the Centers about the development of clinically relevant goals. 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 six of the eight individuals reviewed for this outcome, the dental goals the respective IDTs developed only referenced improving and/or maintaining the current level of their periodontal disease or their poor to fair oral hygiene status. Individual #357's goal was simply to receive dental care to meet her needs, while the Integrated Health Care Plan (IHCP) documentation submitted for Individual #226 did not reference a dental goal. Overall, the goals did not address the specific reasons the individuals had periodontal disease or poor/fair oral hygiene (i.e., the specific etiology or cause of the problem) or how those reasons could be individually addressed. So, asking why individuals had issues with periodontal disease or oral hygiene and developing a goal/objective to address the specific "why" also might have been a place to start (e.g., need for skill acquisition, increase

in tolerance for staff brushing their teeth, need to floss teeth, need to follow a routine, etc.). 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.

The Monitoring Team completed full reviews for all nine individuals. Individual #255 was edentulous and at low risk for dental care, but was part of the core group.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not Rated (N/R)									
Comments: a. 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 and implemented a process to ensure inter-rater reliability with the Centers.											

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Overall, the Center made progress with regard to the provision of dental treatment, but needed to focus on the provision of fluoride treatments for individuals with medium or high caries risk. If the Center sustains its progress with regard to the completion of necessary dental x-rays, and timely restorative work for individuals in need of that care, Indicators c and e might move to the category requiring less oversight after the next review. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
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.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	N/A	1/1	1/1
b.	Twice each year, the individual and/or his/her staff receive tooth-	100%	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1

	brushing instruction from Dental Department staff.	8/8									
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.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	N/A	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.	0% 0/3	N/A	N/A	0/1	0/1	N/A	N/A	N/A	0/1	N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 3/3	N/A	N/A	1/1	1/1	N/A	N/A	N/A	1/1	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 with this indicator, it moved to the category of requiring less oversight.									

Comments: a. through d. Individual #255 was edentulous. Four of eight individuals reviewed received timely dental care on an as-needed basis. Concerns with regard to the four individuals who did not receive needed care included the following:

- Based on the documentation submitted for review, Individual #346, Individual #400, and Individual #362 had medium and high caries risk, but did not receive least two topical fluoride applications per year.
- Based on the documentation submitted for review, the Center had not provided Individual #215 with needed deep cleaning or completed x-rays for him in accordance with the American Dental Association Radiation Exposure Guidelines.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: Indicators a and c are at risk of returning to active oversight due to poor performance.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	Due to the Center's sustained performance with these indicators, they moved to the category of 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: On 5/8/19, Individual #400 was involved in an altercation. Nursing staff made one IPN entry documenting that the individual had bleeding "coming from the mouth." The nurse also noted that "the tooth appears to be sticking out." The nurse contacted the dental clinic and was instructed to bring the individual to the clinic. It was documented that staff was unable to take him to clinic. On 5/9/19, the individual was seen in the dental clinic. The exam and x-rays revealed that tooth #27 was fractured. The dentist started the individual on antibiotics, prescribed pain medication, and referred the individual to an off-campus provider for definitive treatment, which occurred on 5/13/19. It appeared that a medical provider or the dentist should have seen this individual on 5/8/19, in his home to assess the need for emergency dental services, but that did not occur.

As a result, Indicator a and c are at risk of returning to active oversight, unless such issues are corrected by the time of the next review.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.

Summary: These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 7	389	346	400	215	357	255	362	226
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/2	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/2					0/1				0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/2					0/1				0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/2					0/1				0/1

Comments: a. For the two applicable individuals, IDTs did not include measurable suction tooth brushing strategies/plans in their ISPs/IHCPs. Concerns in this area included the following:

- For Individual #215, IHCP interventions provided only broad statements (i.e., to provide for the use of suction tooth brushing and for dental to evaluate suction tooth brushing), and did not include expectations for frequency or duration or a monitoring schedule.
- For Individual #226, the ISP narrative included a recommendation for a service objective, which stated "…will have her oral care completed by staff, with a suction toothbrush, at least 2 times daily through 02/21/2020," but the IDT did not include this as an action plan or strategy in the ISP/IHCP.

b. Based on documentation submitted, the Center did not provide evidence staff implemented suction tooth brushing.

c. The ISP action plans for Individual #215 did not define any expectation with regard to the monitoring frequency needed to ensure quality of the technique. As a result, the Monitoring Team could not determine whether or not the frequency was sufficient. As indicated above, the ISP/IHCP for Individual #226 did not include a goal or strategy for suction tooth brushing. 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." Moving forward, IDTs should ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring and it is implemented according to the schedule.

d. QIDP reports did not include any data with regard to suction toothbrushing. Moving forward, specific suction tooth brushing data is needed to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions).

Additionally, a second data subset is needed on the number of such events during which the individual completed the expected duration of suction tooth brushing (e.g., of the 60 completed sessions, in 12 sessions the individual completed two minutes of suction tooth brushing).

Outcome 9 – Individuals who need them have dentures.											
Summary: Overall, it was positive that individuals with missing teeth had received assessments to determine whether dentures were appropriate, with clinically justified recommendations. This reflected progress from the previous review. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. For eight individuals reviewed with missing teeth, the Dental Department provided clinical justification for not recommending dentures. Of note, though, one individual (i.e., Individual #255) did had a full set of upper and lower dentures, but the Monitoring Team noted that staff reported he was dissatisfied with them. It was unclear why he was dissatisfied (e.g., poor fit, causing irritation, etc.), but dental staff should assess his needs to see if modifications are required.											

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: For the three acute events reviewed, nurses only sometimes followed relevant guidelines with regard to the completion of necessary initial assessments. Improvements also are needed with regard to the completion of acute care plans when needed, the quality of acute care plans, and nurses' implementation and/or documentation of the completion of the assessments and other interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical	33% 1/3	N/R	1/1	N/R	N/R	0/1	N/R	N/R	N/R	0/1

	assessments) are performed.										
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.	67% 2/3		1/1			1/1				0/1
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/2		N/A			0/1				0/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/1		0/1			N/A				N/A
e.	The individual has an acute care plan that meets his/her needs.	0% 0/3		0/1			0/1				0/1
f.	The individual's acute care plan is implemented.	33% 1/3		0/1			0/1				1/1

Comments: Given that State Office recently provided training and Center staff are at the beginning stages of developing and implementing acute care plans that reflect the training, the Monitoring Team reviewed a small number of acute care plans. Specifically, the Monitoring Team reviewed three acute illnesses and/or acute occurrences for three individuals, including those for Individual #389 for a laceration to his chin on 4/29/19, Individual #215 for blisters to his left inner knee on 1/3/19, and Individual #226 for para-influenza and a skin integrity issue on 4/23/19.

e. Nursing staff did not develop and/or implement an acute care plan for Individual #215. Common problems with the other two acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing guidelines; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing staff would measure; and the frequency with which monitoring should occur.

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

- In an IPN, dated 4/29/19, at 10:12 a.m., a nurse noted in her subjective observation: "overnight put [Individual #389] in wheelchair [sic] morning staff found him on shower floor with cut under chin." The assessment noted: "post fall and impaired skin integrity related to laceration to lower left chin." Consistent with applicable nursing guidelines, the nurse documented notification of the RN, and the physician, who ordered transfer of the individual to the ED. Prior to the individual's transfer, the nurse followed applicable nursing guidelines in assessing the individual after a fall, including skin integrity and neurological assessments. A corresponding medical IPN was not found.

  Upon the individual's return from the ED, nursing staff followed nursing guidelines for falls, and skin integrity, but not for neurological assessments, which were warranted due to the potential head injury.

  On 4/29/19, at 1:13 p.m., nursing staff initiated an acute care plan. The acute care plan included an outcome related to impaired skin integrity, but did not address the individual's fall. The acute care plan interventions included: 1) monitor

laceration site for drainage, swelling, and redness twice a day (BID); 2) Monitor for signs and symptoms of pain, such as crying, and facial grimacing BID; 3) Administer PRN pain medication, if needed; 4) DSP instructed - 1; and 5) DSP detailed instructions provided to staff via Care Tracker. Some of the problems with the acute care plan included that it required a pain assessment only BID, which was not in sync with the frequency nursing staff could administer Tylenol as pain medication; it did not included infection control practices; it lacked bathing instructions for the affected area; and it did not include vital sign assessments every shift for 24 hours in alignment with the falls assessment guidelines, as well as the skin integrity assessment guidelines.

With regard to implementation of the acute care plan and related assessments, it was positive that even though the plan did not include vital sign assessments every shift, nursing staff completed them. However, based on review of IPNs and IView entries, nursing staff did not complete the skin integrity assessments as defined in the acute care plan.

- For Individual #215's blisters on his left inner knee, the nurse conducting the initial assessment did not follow standards of care. More specifically, according to the documentation, dated 1/3/19, at 12:27 a.m., the nurse did not complete an assessment to obtain baseline vital signs, or document measurement of the depth or height of the blister. Based on an IPN, dated 1/3/19, at 12:53 p.m., an RN documented follow-up to the blisters on the left inner knee. The record documented "light pink area with one blister no longer intact and one 1cmx.04 clear filled blister… area not on a pressure point… pink area blanchable…" Based on a medical IPN, dated 1/3/19, 4:19 p.m., nursing staff notified the PCP in the morning. The PCP's assessment was: "skin disintegrity, likely abrasion from pressure." The plan was to obtain a head-of-bed elevation (HOBE) evaluation.

  A Habilitation Therapy note, dated 1/3/19, at 3:50 p.m., described "a skin tear surrounded by redness on the upper medial aspect of his left knee." Habilitation Therapy staff noted that a possible cause might be the individual's skin rubbing against his catheter tube. Their instructions to staff included "to be mindful where the catheter is placed during reposition [sic] and check and change and keep pillow between his knees when sideling."

  The RN nursing IPNs, dated 1/3/19, at 12:53 , and 1/4/19, at 2:47 p.m., did not follow nursing guidelines for assessments of a skin impairment, including measurements, and assessment of the individual for discomfort. Nursing staff did not develop and/or implement an acute care plan for Individual #215.
- On 4/22/19, at 5:59 a.m., staff notified the nurse that Individual #226 has a red area under her nose. The note indicated that the individual's face was red from the sun, and the area under her nose was peeling. The individual also had bilateral clear nasal drainage. The Licensed Vocational Nurse (LVN) notified the RN. An RN assessment was not found. In an IView entry, dated 4/23/19, at 7:00 p.m., a nurse noted drooling; a cough, which was described as infrequent and productive with frothy, thin white sputum; and congestion. The individual's temperature was low (i.e., 96.8). A corresponding IPN was not included in the submitted records. Nursing assessments were not in alignment with applicable nursing guidelines. In a medical IPN, dated 4/24/19, the PCP noted follow-up for another problem, but also noted that the individual was symptomatic with respiratory congestion, a cough, and increased oral secretions.

  Center staff submitted an acute care plan, dated 4/25/19, at 11:10 p.m. Based on her signs and symptoms on 4/23/19, the plan should have been developed earlier. The acute care plan did not contain necessary baseline information to describe the reason for the acute care plan. The outcomes/goals in the plan were not specific and measurable. The DSP instructions did not

coincide with the nursing interventions. On a positive note, the acute care plan did include nursing assessment interventions that were consistent with applicable guidelines. In addition, once the ACP was initiated, nursing staff implemented the interventions in alignment with the individual's signs and symptoms.

As part of the onsite review week, the Monitoring Team appreciated the Program Compliance Nurse, as well as the Chief Nurse Executive (CNE), and the Nursing Operation Officer's willingness to conduct an objective review of one acute care plan for one of the individuals reviewed, and discuss their findings openly with the members of the Monitoring Team and State Office staff. The Program Compliance Nurse did a nice job presenting the findings of the Center's review to the group. This effort showed Center staff's ability to identify strengths, as well as weaknesses in the acute care plans and the related nursing assessments, as well as to identify potential solutions to the significant improvements that are needed. The Monitoring Team is hopeful that such audits will continue and result in constructive feedback to nurses, and that at the time of the next review improvements will have occurred in the quality of the acute care plans and their implementation.

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.

#	Indicator	Overall Score	Individuals: 7	389	346	400	215	357	255	362	226
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	0/2	0/2	0/2	0/2	1/2	2/2
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 specific risk areas (i.e., Individual #7 – seizures, and constipation/bowel obstruction; Individual #389 – respiratory compromise, and falls; Individual #346 – diabetes, and fractures; Individual #400 – dental, and GI problems; Individual #215 – respiratory compromise, and constipation/bowel obstruction; Individual #357 – skin integrity, and falls; Individual #255 – GI problems, and aspiration; Individual #362 – choking, and cardiac disease; and Individual #226 – infections, and weight).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used

to measure the individual's progress or lack thereof: Individual #362 – choking, and Individual #226 – infections, and weight.

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.

#	Indicator	Overall Score	Individuals: 7	389	346	400	215	357	255	362	226
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.	17% 2/12	0/1	0/2	0/1	N/A	0/2	0/1	2/2	0/2	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).	22% 4/18	0/2	2/2	1/2	0/2	0/2	0/2	0/2	1/2	0/2

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

a. 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 generally was 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 exceptions were for Individual #389 – respiratory compromise, and falls; Individual #346 – diabetes; and Individual #362 – choking.

b. The following provides a positive example of an IDT's responses to an individual's changes of status:

- On 10/31/18, Individual #255's IDT met to discuss his G-tube placement. They developed a change-of-status IRRF, and increased his risk ratings for GI problems and aspiration from medium to high, and added interventions to his IHCP.

However, as illustrated below, a significant problem at the Center was the lack of urgency with which IDTs addressed individuals' changes of status through the completion of comprehensive reviews and analyses to identify and address underlying causes or etiologies of conditions that placed individuals at risk. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- On 5/14/19, Individual #7 experienced a seizure with a four-minute postictal period, and on 6/5/19, she had a seizure that required an IM Stat dose of medication, as well as the use of oxygen. Despite a notation that this represented an "acute change from baseline," the IDT did not hold an ISPA meeting.
- On 2/28/19, Individual #389 was diagnosed with bilateral pneumonia. As identified elsewhere in this report, despite a high risk rating for respiratory compromise, his IDT had not developed an IHCP that met his needs. Despite the diagnosis of pneumonia, his IDT did not hold an ISPA meeting to discuss needed changes to the IRRF and/or IHCP.
- On 4/30/19, the IDT held an ISPA meeting to discuss an allegation after Individual #389 was found on floor, on 4/29/19, in the shower with a laceration on his chin from a fall. The IDT discussed that in the past six months, this was the third serious injury the individual had sustained related to falls (i.e., on 12/31/18, a laceration to the brow above his right eye; and on 12/21/18, a laceration to his chin). The IDT discussed the "root cause" of the injury, and concluded that it was due to the unsecured lap belt, and the individual's ability to independently unbuckle the belt. However, the IDT did not ask/answer the "why" questions to the extent necessary to identify a "root cause." For example, "why did Individual #389 regularly unbuckle his seatbelt and try to get out of his wheelchair on his own?" Moreover, although the IDT listed seven recommendations (e.g., one-to-one staffing until the injury healed, re-train staff on need for proper footwear when individuals are in wheelchairs, no pulled staff working with individual), the IDT did not modify the IRRF or IHCP, and evidence was not found to show the IDT conducted follow-up on the recommendations it made. According to Tier I documentation, in June 2019, Individual #389 fell three additional times in his bedroom.
- On 2/11/19, Individual #346 fractured his left ankle. On 5/14/19, on the day before his ISP meeting, he experienced a second fracture to his left lateral malleolus. He required surgery for both fractures. Based on a review of the ISPA, dated 2/21/19, the IDT increased his risk level to high due to the fracture. However, the IDT discussed no nursing recommendations or interventions. According to the ISPA, dated 5/16/19, the IDT discussed the emergency restriction, and the record stated "ACP [acute care plan] was initiated for altered comfort and R/F impaired tissue perfusion." The record also included the following statement: "In reviewing footage, [Individual #346] fell on his right side. He had just gotten up from the sofa while in the living room. He was walking to the water fountain and then it appeared his right leg just gave out. The entire fall couldn't be viewed due to the camera angles." The IDT did not review the ACP to determine if it met the individual's needs. Moreover, no IHCP was submitted to address this individual's falls/fractures, nor did any of the ISPAs submitted after this date address follow-up with regard to his falls and fractures.
- On 5/24/19, 6/7/19, 6/12/19, and 6/13/19, Individual #215 had constipation that required suppositories, and/or KUB enemas. Additionally, on 5/3/19, and 6/14/19, the PCP increased his medication to treat constipation. However, the IDT did not hold ISPA meetings that addressed his constipation issue.
- Individual #357 experienced numerous falls. Between 4/11/18 and 3/9/19, she experienced as many as 63 falls. With an additional 15 since that time on (i.e., on 3/26/19, 3/20/19 x 2, 4/9/19, 4/17/19 x 3, 4/27/19, 5/4/19, 5/8/19, 5/19/19, 5/24/19, 5/30/19, 5/31/19, and 6/9/19). Although on 5/13/19, 5/31/19, and 6/26/19, the IDT held ISPA meetings to discuss her falls, the nursing interventions in the IHCP were generic (e.g., performing annual and quarterly assessments), and

the IDT did not modify them to include proactive nursing assessments to potentially assist the IDT in further identifying and addressing the underlying cause(s) of the individual's falls.

- For Individual #362, the IDT held an ISPA meeting following his choking event on 1/14/19, when he choked on pizza. Although the IDT increased his risk rating to high, the IDT did not identify specific, clinically relevant goals related to the etiology of the individual's choking risk (e.g., a SAP to increase the individual's ability to moderate his eating pace or the size of the bites of food), nor did they include nursing interventions in his IHCP to address his needs. Again, on 2/20/19, he choked on hamburger, but the IDT did not make needed changes to his IHCP.
- Individual #362 was at increased risk for cardiovascular disease (e.g., per his QDDRs, dated 3/1/19, and 6/3/19, his 10-year Cardiovascular Risk was 4.6%, and 8.9%, respectively). The individual had a tobacco dependence, and family history for hyperlipidemia. In May 2017, a course of atorvastatin was initiated, secondary to hypertriglyceridemia, but in May 2018, the atorvastatin was discontinued. Per the QDDR, on 5/15/19, the PCP ordered Fenofibrate to reduce the individual's cholesterol and triglyceride levels. In the submitted documents, no ISPAs were found to show that the IDT discussed the significance of the findings related to his increased risk, or the actions in which the individual could participate to reduce his risk.
- Based on an ISPA, dated 5/29/19, Individual #226's IDT met to discuss her hospitalization from 5/17/19 to 5/21/19, for septic shock due to Escherichia coli and staphylococcal septicemia, and aspiration pneumonia. The ISPA noted the IDT reviewed the acute care plan, and direct support professional care instruction were initiated and staff were trained. However, the IDT did not review her IHCP to determine whether or not staff had implemented the interventions, and whether or not the preventative interventions were sufficient or required revision.

Outcome 7 – Individuals receive medications prescribed in a safe manner.

Summary: For at least the three previous reviews, as well as this review, the Center did well with the indicator related to nurses administering medications according to the nine rights. It was also positive that during this review, when issues arose during medication administration observations (i.e., infection control), the Center's nurse auditor identified the same issues as the Monitoring Team member, and took steps to address them, as necessary. If the Center's high level of performance with Indicator c, and the Center's ability to self-monitor continues, after the next review, this indicator might move to the category requiring less oversight.

Center staff need to focus on the completion of respiratory assessments for individuals at high risk for respiratory compromise that are consistent with the individuals' level of need. At this time, all of these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 7	389	346	400	215	357	255	362	226
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R				N/A					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% 7/7	1/1	1/1	1/1		1/1	1/1	1/1	1/1	
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	N/A									
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	N/A									
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	0% 0/4	N/A	N/A	0/1	N/A	0/1	N/A	0/1	N/A	0/1
	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.	33% 2/6	N/A	0/1	N/A	N/A	1/2	N/A	1/2	0/1	N/A
	a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	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.	100%	1/1	1/1	1/1		1/1	1/1	1/1	N/A	

		6/6									
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	N/A									
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	N/A									
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	71% 5/7	1/1	1/1	1/1		0/1	1/1	1/1	0/1	
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1	
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	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 seven individuals, including Individual #7, Individual #389, Individual #346, Individual #215, Individual #357, Individual #255, and Individual #362. Individual #400 had moved to another SSLC, and due to scheduling issues, including a power outage, the Monitoring Team member was unable to observe a medication administration session for Individual #226.

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

d. For the individuals reviewed, the Monitoring Team identified a number of concerns related to necessary respiratory assessments. The following provide examples of the Monitoring Team's findings:

- On 2/28/19, Individual #389 was diagnosed with bacterial pneumonia. Neither his IHCP nor the acute care plan defined respiratory/lung sound assessments.
- Individual #346 was at high risk for respiratory compromise due to his smoking history, asthma, restrictive lung disease, and obesity. His IHCP included an intervention to monitor lung sounds monthly. Based on a review of a sample of records, nursing staff had not completed specific respiratory/lung sound assessments.
- During the onsite medication administration observation, the medication nurse assessed Individual #215's lung sounds, which was good to see. His IHCP included an intervention to assess his lung sounds with every medication pass. However, the sample of documentation reviewed did not show that nurses completed such assessment during medication passes, because IView does not specify the circumstances under which assessments are completed (e.g., medication administration).
- According to an IRRF addendum, dated 3/26/19, Individual #255's IDT elevated his respiratory compromise risk from medium to high. Based on review of a sample of documentation, the Monitoring Team was not able to confirm implementation of the intervention related to lung sound assessments. During the onsite medication administration observation, the medication nurse assessed the individual's lung sounds.
- Individual #362 took his pills whole with a small medicine cup (i.e., Solo paper medicine cup graduated three-ounce cup) in which the MiraLAX (a powder) was mixed with water to address his preference. Although he did not have PNMP instructions related to medication administration, the individual's PNMP noted he needed prompts to slow his pace while eating. During the medication observation, he coughed and vocalized words at the same time; he did not have watery eyes, and self-reported verbally that he was okay. After further review of his records, which documented two recent choking events requiring use of the abdominal thrust, the Monitoring Team member met with the Program Compliance Nurse, who agreed to determine what the medication nurse had documented. In talking with the Program Compliance Nurse, this appeared not be the first occurrence of this type. In addition, of greater concern, the Compliance Nurse reported that in reviewing IRIS documentation, the medication nurse had not documented this event. As discussed with Nursing Department staff while the Monitoring Team was on site, when individuals display such symptoms, nursing staff need to document the event(s), track the individual's progress, and identify whether or not the individual is having or is headed toward a change of status with regard to medication administration, and/or if revised techniques are needed (e.g., use of the cup).
- Documentation did not show implementation of required respiratory assessments for Individual #226.

f. For the individuals reviewed, medication nurses followed the individuals' PNMPs, including checking the positions of the individuals prior to medication administration.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. It was positive that when problems did occur, the Center's nurse auditor identified them, and took corrective action as needed. The following concerns were noted:

- Individual #215 had a soiled towel on his lap, below his lap tray. The medication nurse placed the internal piston syringe on the towel, which increased the likelihood that germs could be introduced. In addition, the medication nurse did not clean/disinfect the stethoscope prior to using it, although the nurse did clean the stethoscope after completing lung sounds.
- For Individual #362, the medication nurse did not sanitize the bandage scissors prior to opening the package of polyethylene glycol. The Center's nurse auditor identified the issue, and addressed it with the medication nurse.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Improvement was needed with regard to the timely review of individuals to the PNMT, when needed. Overall, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
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	N/A	0/2	0/1	0/2	0/2	0/1	0/1	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/12		0/2	0/1	0/2	0/2	0/1	0/1	0/1	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12		0/2	0/1	0/2	0/2	0/1	0/1	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12		0/2	0/1	0/2	0/2	0/1	0/1	0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12		0/2	0/1	0/2	0/2	0/1	0/1	0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	50% 3/6	2/2	N/A	0/1	N/A	N/A	0/1	0/1	1/1	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/2		0/1			0/1	0/1	0/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6	0/2		0/1			0/1	0/1	0/1	
	iv. Integrated ISP progress reports include specific data	0%	0/2		0/1			0/1	0/1	0/1	

	reflective of the measurable goal/objective;	0/6									
v.	Individual has made progress on his/her goal/objective; and	0% 0/6	0/2		0/1			0/1	0/1	0/1	
vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/2		0/1			0/1	0/1	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 # 389 – aspiration, and falls; Individual #346 – weight; Individual #400 – choking, and falls; Individual #215 – skin integrity, and aspiration; Individual #357 – choking; Individual #255 – falls; Individual #362 – choking; and Individual #226 – aspiration, and skin integrity.

a.i. and a.ii. For these risk areas, none of the individuals had goals/objectives that were clinically relevant, achievable, and/or measurable.

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 #7 – weight, and falls; Individual #346 – fractures; Individual #357 – falls; Individual #255 – aspiration; and Individual #362 – choking.

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

- For Individual #346's risk for fractures, no current IHCP was found. According to the IRRF, in 2018, his IDT rated him at low risk, but his status changed in 2019. In February 2019, he fractured his left ankle while on a visit to a day habilitation program in the community. On 5/14/19, on the day before his ISP meeting, he experienced a second fracture to his left leg. He required surgery for both fractures. Both resulted from falls, potentially related to seizure-like activity, which the individual reported as shaking. The IRRF indicated that he had "Numerous falls in the last year," including falls on 12/19/18, 1/30/19 (described as "fall on right ankle," per ISPA held on 2/12/19), 1/12/19, 4/8/19, 5/8/19, and 5/14/19 (i.e., ankle fracture on 2/11/19, due to fall not listed). An ISPA indicated that he had no history of seizures, and the IDT hypothesized he might be anxious about transitioning to the community. On 5/14/19, the second fracture reportedly was related to a fall, when he was getting up from the sofa, and his "right leg went out." This was a fracture to the left leg with the fracture above his left ankle per an ISPA held on that date. Staff observed him fall on his right side, yet the break was on the left. According to the ISPA, the RN was notified that the fracture was higher on left leg rather than the ankle, and it was not clear if the fractures were related to this fall or a previous one. The PCP was present at the ISPA meeting, and indicated that there was no fracture. However, the direct support professional, who attended the orthopedic appointment that day, stated that the orthopedist determined that there was a fracture in the upper tibial plateau above the plate in his leg from a previous fracture. Despite the fact that this was his second fracture in three months, his IDT did not refer him to the PNMT.
- For Individual #357, referral to the PNMT for falls was indicated in November 2017, December 2017, July 2018, August 2018, and September 2018. Between 4/11/18 through 3/9/19, she experienced as many as 63 falls. With an additional 15 since that time (i.e., on 3/26/19, 3/20/19 x 2, 4/9/19, 4/17/19 x 3, 4/27/19, 5/4/19, 5/8/19, 5/19/19, 5/24/19, 5/30/19, 5/31/19, and 6/9/19).
- On 2/11/19, the PNMT conducted a review for Individual #255. From 10/19/18 to 11/1/18, he was hospitalized for bacterial

pneumonia and PEG- tube placement. He was weaned from supplemental oxygen and gradually resumed oral eating working up to double portions and taking medications orally on 11/15/18. From 12/23/18 to 1/18/19, he was hospitalized with aspiration pneumonia, and had a tracheostomy placed. He pulled it out a few times, and it was removed prior to discharge. It was not clear why the PNMT did not complete a comprehensive evaluation when he was discharged the first time. The review was not completed for 24 days after the second hospitalization and over three months after tube placement (103 days).

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: None of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that individuals receive the PNM supports they require. In addition, in numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. At this time, these indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
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% 0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/1	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.	9% 1/11	1/2	0/2	0/2	N/A	0/1	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.	50% 1/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	0/1	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, monthly integrated reviews generally did not provide 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:

- On a positive note, on 11/28/18, Individual #7's IDT met in response to her weight loss and meal refusals. They made a referral to psychiatry, and added Ensure twice a day. The Registered Dietician (RD), and PNMT representative participated in the meeting, and the IDT decided to make a referral to the PNMT for a review. The individual's issues resolved with snacks and supplements, and the PNMT conducted monitoring.
- Individual #7's IDT held many ISPA meetings to discuss falls and peer-to-peer incidents, but they made few changes in actions to actually address the issues. The ISPAs related to peer-to-peer aggression frequently also implicated falls (e.g., 10/30/18, 11/5/18, 11/29/18, 12/3/18, 12/17/18, 12/19/18 regarding an abuse allegation on 12/5/18, 12/21/18, 1/2/19, 1/7/19 regarding abuse allegation follow-up, 1/22/19, 2/7/19, 2/25/19, 4/26/19, and 7/1/19). Also, the IDT held ISPA meetings to discuss three falls in 30 days, including on 12/4/18 (falls identified on 11/26/18, 11/28/18 - pushed, and 12/3/18. During this meeting, the IDT discussed a vision assessment, dated 10/17/18, and recommended a clear environment, that staff follow the PBSP, Habilitation Therapy staff were to research special shoes by 12/21/18, staff were to take all purchased shoes to Habilitation Therapy to ensure insoles were glued down, the individual was to see the psychiatrist, Behavioral Health Services (BHS) staff were to compile sleep data, maintenance was to address the floor fans in the homes, and the IDT was to review her level of supervision (LOS), and discuss risk levels during the annual ISP on 12/6/18. At the ISP meeting, the IDT rated her at high risk for falls. On 12/17/18, the IDT held another ISPA meeting (i.e., for three falls in 30 days, including falls on 12/10/18, 12/15/18, and 12/16/18 – pushed). The IDT made the same recommendations as they had on 12/4/18. At a serious injury ISPA meeting, on 1/15/19 (i.e., finger fracture of unknown cause) the IDT made no changes in supports. The IDT held other ISPA meetings, but made few changes to the plan (e.g., 2/23/19, 2/27/19, 3/2/19, 3/5/19 - BHS to review PBSP regarding target behaviors with staff during huddles, and 4/13/19 - related to LOS after an ankle fracture due to fall from a people mover on 4/13/19). As documented elsewhere in this report, her IHCP for falls did not meet her needs, and despite ongoing falls and serious injuries, the IDT did not modify it in a meaningful way to address her needs.
- Although Individual #389's IDT had evidence that he was drinking from the water fountain, which was not consistent with his prescribed honey-thick liquid consistency, they did not meet to review and change, as needed, his supports.
- With regard to Individual #389's falls, his IDT met on occasion, and developed some interventions, but overall, it was not clear that the interventions effectively addressed the underlying cause of his falls. Moreover, on 4/30/19, the IDT held an ISPA meeting to discuss an allegation after the individual was found on floor in the shower with a cut on his chin from a fall. Staff were supposed to provide him with enhanced supervision. However, the IDT developed no plan to ensure that his supervision needs were met given this significant injury (e.g., enhanced monitoring to ensure staff adhered to the supervision plan and implemented the PNMP).
- Individual #346 experienced weight loss while recovering from his long bone fracture. However, evidence was not found to show the IDT had addressed it.
- Individual #215 had a history of pressure ulcers, including a sacral wound, which was considered healed as of 7/5/18, and a right trochanter wound, which was considered healed as of 9/26/18. Per PNMT notes, dated 9/27/18, the PNMT made a number of recommendations, one of which was to implement pending supports, which included obtaining an airflow mattress. Notes indicated that he no longer qualified for a pressure relieving mattress. On 10/11/18, the right trochanter area had a blister and redness, which was diagnosed as a reoccurrence of the Stage 1 pressure ulcer, progressing to a Stage 2 ulcer. Notes indicated that the SSLC would purchase the airflow mattress. No evidence was found to show that the IDT revised the IHCP at

any time. On 10/26/18, the Rojo cushion was overinflated, and the PNMP Coordinator was to re-in-service staff related to use of the Rojo cushion. On 10/29/18, new orders from the wound care consult indicated the individual was to be out of bed only four hours per day rather than six hours as before. While the IDT did discuss and document the change in the schedule for bed positioning, specifics of bed positions were not outlined other than that he would continue to stay off his right side due to fragile skin. On 10/31/18, Habilitation Therapy staff revised the PNMP, but the ISPA did not clearly outline all of the changes required. Two weeks earlier, the IDT had discussed that the air flow mattress was approved, and that the QIDP would follow through with its purchase (i.e., he was to purchases his own mattress). At the 10/30/18 meeting, the QIDP asked about the purchase, and the OT stated they were not sure of where they were in the process. There still seemed to be questions as to when and if the mattress would be ordered, despite the identified need for it. It was concerning that the IDT did not challenge Medicare's decision or take immediate steps to have the SSLC pay for the air flow mattress to prevent reoccurrence of the pressure ulcer. It was not until 12/6/18, that the mattress the individual needed was delivered.

- For Individual #357, referral to the PNMT for falls was indicated in November 2017, December 2017, July 2018, August 2018, and September 2018, but the IDT did not make referrals. Between 4/11/18 through 3/9/19, she experienced as many as 63 falls. With an additional 15 since that time (i.e., on 3/26/19, 3/20/19 x 2, 4/9/19, 4/17/19 x 3, 4/27/19, 5/4/19, 5/8/19, 5/19/19, 5/24/19, 5/30/19, 5/31/19, and 6/9/19). Although the IDT held some ISPA meetings, the supports were ineffective at reducing the falls, and it was not clear that the IDT methodically analyzed the cause(s) of the falls and/or the efficacy of the supports, and made changes, as necessary.
- For Individual #362, the IDT held ISPA meetings immediately following both choking events (i.e., on 1/14/19, on pizza, and on 2/20/19, on hamburger). After the second one, the PNMT conducted a review. The IDT increased his risk rating after the first one to high. However, the IDT did not identify specific goals related to the etiology of the individual's choking risk, nor did they include interventions in his IHCP to address his needs.

c. The following provide examples of findings related to individuals' discharge from the PNMT:

- With regard to Individual #362's discharge from the PNMT on 3/28/19, no evidence of an ISPA meeting was submitted to show that the IDT and PNMT met to discuss the ongoing follow-up in which the IDT needed to engage to prevent another choking event.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: Based on observations, problems were noted with regard to transfers, dining plan implementation, and positioning. Often, the errors that occurred (e.g., staff not intervening when individuals ate at an unsafe rate, staff not setting up transfers correctly, and staff not repositioning individuals) 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.	55% 22/40	
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.	N/R	

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during seven out of 10 observations (70%). Staff followed individuals' dining plans during 15 out of 27 mealtime observations (56%). Staff completed transfers correctly during zero out of three observations (0%).

The following provides more specifics about the problems noted:

- With regard to Dining Plan implementation, the problems varied. At times, the errors related to staff not using correct techniques. Individuals were at increased risk due to staff's failure, for example, to intervene when individuals ate at too fast a rate, staff filled cups despite instructions to provide less fluid at a time, or staff did not wait the required time between bites. In other instances, individuals were not positioned correctly. It was good to see that the adaptive equipment used was correct.
- With regard to positioning, three individuals were not positioned correctly, and in one instance, the equipment was not used correctly.
- For the three transfers observed, staff did not complete safe transfers, which placed the individuals and the staff at risk. In two instances, the staff did not set up the transfers correctly. In one of these instances, the Home Supervisor intervened. In the third instance, staff did not use proper body mechanics.

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	7	389	346	400	215	357	255	362	226
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					N/A		0/1		N/A

Comments: a. For Individual #255, the two plans the IDT developed for his return to oral intake did not provide step-by-step interventions with clearly measurable outcomes. In addition, the QIDP monthly reviews did not include data and analysis of the data to assist with the IDT's decision-making regarding the safety and effectiveness of the plan. As noted above, the IDT rapidly progressed him to oral intake with double portions, and he was hospitalized with aspiration pneumonia.

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: Individuals' ISPs reviewed did not include clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/14	0/1	0/1	0/1	0/1	0/4	0/1	0/3	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/14	0/1	0/1	0/1	0/1	0/4	0/1	0/3	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/14	0/1	0/1	0/1	0/1	0/4	0/1	0/3	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/14	0/1	0/1	0/1	0/1	0/4	0/1	0/3	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/14	0/1	0/1	0/1	0/1	0/4	0/1	0/3	0/1	0/1
Comments: a. and b. The goals/objectives that were clinically relevant, and measurable were those for Individual #255 (i.e., sit independently, ambulate at least 600 feet, and sit to stand transfers), but they were not included in his ISP or incorporated through an ISPA. For none of the remaining seven individuals did the respective IDTs develop goals/objectives that were clinically relevant and achievable, as well as measurable. 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. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals.										

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.	
Summary: For the individuals reviewed, OT/PT formal supports had not been incorporated into their ISPs. As a result, evidence was not found in ISP integrated	Individuals:

reviews to show that OT/PT supports were implemented. These indicators will continue in active oversight.											
#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
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.	100% 3/3	N/A	N/A	N/A	N/A	N/A	N/A	3/3	N/A	N/A
Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that OT/PT supports were implemented. OTs and PTs should work with QIDPs to ensure that ISPs include the goals/objectives and other formal supports, and that data are included and analyzed in ISP integrated reviews. b. For the one individual for whom termination of OT/PT services or supports was recommended, it was positive that the IDT met as needed to discuss and approve the changes.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	336	281	331	248	32	239	228	258	23
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category of 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.	69% 18/26	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
		Individuals:									
#	Indicator		265	144	18	3	274	370	213	234	154

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	1/1	0/1	0/1	1/1	1/1
		Individuals:									
#	Indicator		186	389	129	22	230	136	119	307	
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	
Comments: c. The Monitoring Team conducted observations of 26 pieces of adaptive equipment. Based on observations of Individual #336, Individual #228, Individual #23, Individual #265, Individual #370, Individual #213, Individual # 22, and, Individual #119 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.											

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. At the last review, 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.

It was good to see so many staff who were knowledgeable about the individuals they were directly supporting.

For ISP personal goals and their supporting action plans, without implementation and without reliable data, it is impossible to assess/determine progress. At San Antonio SSLC, about 20% of ISP action plans in the five personal goal areas were implemented. This needs to be improved.

The work done on quality of SAPs since the last review was evident. Almost half of the SAPs contained all of the required components and the other half contained most of the components.

For SAPs, however, without reliable data, and without regular implementation, progress could not be determined. There were some examples of when the Center determined that an objective was met, individuals were moved up to the next step. On the other hand, when there was no progress, actions were not taken.

The Center did not maintain high performance in conducting monthly SAP reviews. On the positive, all SAPs had graphic summaries of individuals' performance.

One individual attended public school. Her educational services/IEP were not integrated with her ISP. Years ago, San Antonio SSLC had many students and was regularly meeting the criteria for integration of IEPs and ISPs. Even if there are few students at San Antonio SSLC, the Center should ensure it is meeting the criteria.

San Antonio SSLC continued to attend to engagement in activities (e.g., measurement, activity development, feedback to staff). The Monitoring Team's observations, however, showed lower engagement than at the last review.

Vehicle availability was often cited as a barrier for even more community outings. A number of vehicles were out for repair.

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

The Center should continue to focus on ensuring individuals have their alternative and augmentative communication (AAC) devices with them. Most importantly, 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: Without implementation and without reliable data, it is impossible to assess/determine progress. At San Antonio SSLC, about 20% of ISP action plans in the five personal goal areas were implemented. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	16	390	362	226			
4	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/5	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	1/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	1/6	0/6	0/6	0/6	0/6	0/6			

Comments:
4-7. A personal goal that meets criteria for indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. For this review period, none of the goals met prerequisite criteria. Overall, data were not reliable and monthly reviews did not summarize progress made towards goals, so it was not possible to determine if individuals were making progress and achieving goals. Per QIDP interviews and observations, none of the goals reviewed had been met.

The Monitoring Team, however, noted that for one goal for Individual #7 (independence), the IDT revised the goal after three months of no progress. This was good to see.

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

Outcome 8 – ISPs are implemented correctly and as often as required.												
Summary: It was good to see so many staff who were knowledgeable about the individuals they were directly supporting. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	7	389	16	390	362	226			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. The Monitoring Team's evaluation of this indicator relies upon the input of all its members, based on observations, interviews, and review of documentation that reflects implementation.

For all individuals, staff seemed to be knowledgeable regarding risks and supports needed by individuals.

All staff interaction observed during the week was very respectful and positive.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report. ISPs rarely included detailed instructions to guide staff when implementing the ISP. A review of QIDP monthly reviews and SAP data sheets indicated that less than half of action plans were ever implemented and many that were implemented were not implemented consistently and/or correctly.

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.

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: Without reliable data, and without regular implementation, progress could not be determined. There were some examples of when the Center determined that an objective was met, individuals were moved up to the next step. On the other hand, when there was no progress, actions were not taken. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
6	The individual is progressing on his/her SAPs.	0%	0/2	0/2	0/3	0/2	0/2	0/1	0/3	0/2	0/2

		0/19									
7	If the goal/objective was met, a new or updated goal/objective was introduced.	100% 2/2			1/1		1/1				
8	If the individual was not making progress, actions were taken.	0% 0/8	0/2			0/1	0/1	0/1	0/3		
9	(No longer scored)										

Comments:
6. Some SAPs were not progressing (e.g., Individual #257's put on his seatbelt SAP). Several other SAPs were progressing (e.g., Individual #95's wash her hair SAP), however, they did not demonstrate that the data were reliable (indicator #5) and therefore were scored as zero. Finally, some SAPs had insufficient data to determine progress, but were scored as zero because their data were not demonstrated to be reliable (e.g., Individual #68's make a scrapbook SAP).

7. Both of the SAP objectives that were achieved (based on Center data) were moved to the next step (i.e., Individual #95's wash her hair SAP, and Individual #16's make a purchase SAP). Individual #390's shop for ingredients SAP, was moved to the next before she achieved mastery criterion.

8. None of the SAPs that were not progressing included actions to address the lack of progress (e.g., Individual #358's count bills SAP). San Antonio SSLC should prioritize timely action (e.g., retrain staff, modify SAP, discontinue SAP) when the individual is not progressing.

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

Summary: The work done on quality of SAPs since the last review was evident in the scores for this indicator. Almost half of the SAPs contained all of the required components and the other half contained most of the components. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
13	The individual's SAPs are complete.	42% 8/19	1/2 19/20	1/2 19/20	0/3 27/30	1/2 19/20	0/2 17/20	0/1 7/9	2/3 28/29	1/2 18/19	2/2 20/20

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.

Forty-two percent of the SAPs reviewed were judged to be complete (e.g., Individual #390's make change SAP). This represents a substantial improvement from the last review when eight percent of the SAPs were found to be complete. Additionally, 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
- relevant discriminative stimuli
- teaching schedule
- specific consequences for incorrect responses
- documentation methodology.

Regarding common missing components:

- Clear SAP training instructions were often missing. For example, in some multiple-step SAPs, the training instructions did not clearly indicate if training should occur on one step or multiple steps at each training session (e.g., Individual #358's count money SAP, Individual #390's shop for ingredients SAP). Other multiple step SAPs directed staff to assist the individual to complete all remaining steps in the task analysis. However, the instructions did not indicate how staff should respond and score if an earlier mastered step now required prompting (Individual #68's fill a bag of towels SAP).
- 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 #7's make a sno-cone SAP where correct responses were to be followed by praise, and the opportunity to consume the sno-cone).
    - Many SAPs, however, merely included saying "good job," which may not function as a potent reinforcer for every individual (e.g., Individual #257's put on his seatbelt SAP).
- Most SAPs had complete generalization and maintenance plans. Some, however, did not have a complete generalization plan (e.g., Individual #389's watch TV SAP).
- Finally, the training instructions section should include the staff's behavior to teach the skill steps. Several SAPs, however, included individual and staff behavior in other sections of the SAP training sheet, resulting in confusing staff instructions (Individual #142's make coffee SAP).

Outcome 5- SAPs are implemented with integrity.

Summary: The quality (integrity) of SAP implementation observed by the Monitoring Team improved since the last review. The percentage of SAPs that met the Center's own goals for checking integrity and the quality of the implementation decreased since the last review. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 7	389	95	68	16	358	257	390	142
14	SAPs are implemented as written.	67% 4/6	1/1			1/1	0/1		1/1	1/1	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured)	16%	2/2	0/2	0/3	0/2	1/2	0/1	0/3	0/2	0/2

	and a goal level (i.e., how high it should be) are established and achieved.	3/19									

Comments:
14. The Monitoring Team observed the implementation of six SAPs. Individual #68's make a scrapbook, Individual #257's activate his music, Individual #390's buy ingredients, and Individual #7's make a sno-cone SAPs were judged to be implemented with integrity and scored accurately.

Individual #16's laundry SAP, and Individual #142's make coffee SAPs, however, were not implemented as written and/or scored accurately. This represents another improvement from the last review when 20% of the SAPs observed were implemented and scored with integrity.

15. San Antonio SSLC 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. They achieved this goal for Individual #16's laundry, and Individual #7's make a sno-cone and shred paper SAPs. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. San Antonio SSLC should ensure that all SAPs have regular integrity checks.

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

Summary: San Antonio SSLC did not maintain high performance in conducting monthly SAP reviews. On the positive, all SAPs had graphic summaries of individuals' performance. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
16	There is evidence that SAPs are reviewed monthly.	26% 5/19	2/2	2/2	0/3	1/2	0/2	0/1	0/3	0/2	0/2
17	SAP outcomes are graphed.	100% 16/16	2/2	2/2	2/2	2/2	2/2	1/1	3/3	2/2	

Comments:
16. Individual #68's fill a bag of towels, Individual #389's sign watch TV and sign done, and Individual #7's make a sno-cone and shred paper SAPs had monthly data reviews.

Some SAPs, however, were not reviewed in QIDP monthly reports (e.g., Individual #358's count bills SAP), others did not include SAP data (e.g., Individual #68's make a scrapbook SAP), and others were not regularly reviewed (e.g., Individual #142's make coffee SAP was last reviewed in March 2019).

17. All of the SAPs with data were graphed.

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	7	389	95	68	16	358	257	390	142
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found two (Individual #390, Individual #142) to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

21. The facility's average engagement data over the last six months indicated that none of the individuals' residences achieved their goal level of engagement.

Although both the facility's and the Monitoring Team's engagement scores are below those reported in the last review, the Monitoring Team continues to be impressed with San Antonio SSLCs engagement data process and activities (i.e., the way in which data are collected, the accuracy of their self-scoring), and looks forward to seeing improvements in this area in the next review.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Community outings were occurring frequently at San Antoni SSLC. In fact, a number of staff said they wanted to go out with individuals even more, but van repairs/availability was sometimes a barrier. It was good to see that community outing goals were set for each individual (and met for about half). There were more community SAPs than in the past, too. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	7	389	95	68	16	358	257	390	142
22	For the individual, goal frequencies of community recreational activities are established and achieved.	56% 5/9	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1

23	For the individual, goal frequencies of SAP training in the community are established and achieved.	17% 1/6				0/1	1/1	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% 0/6				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 #95, Individual #390, Individual #257, Individual #358, Individual #7, and Individual #16 achieved their community outing goals.

Individual #142, Individual #390, Individual #257, Individual #358, Individual #68, and Individual #16 had SAP training in the community goals. Individual #16 achieved his SAP training in the community goals. The IDTs determined for the other three individuals that a community-based SAP was not a priority and, therefore, they did not have any community-based training SAPs. It was good to see that these IDTs gave some thoughtful consideration to this decision.

Although only Individual #16 achieved his community SAP goals, it was encouraging to see that six individuals had community SAP training goals.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.

Summary: Individual #390 was the only individual who attended school. Her educational services/IEP were not integrated with her ISP. Years ago, San Antonio SSLC had many students and was regularly meeting the criteria for this indicator (and sub-indicators). Even if there are few students at San Antonio SSLC, the Center should ensure it is meeting the criteria. Given past performance, the Monitor will keep this indicator in the category of less oversight, but it needs to be corrected in order for it to remain in this category after the next review.

Individuals:

#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For the individuals reviewed, the 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	7	389	346	400	215	357	255	362	226
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4	0/1	0/1	0/1	N/A	N/A	N/A	N/A	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/4	0/1	0/1	0/1					0/1	
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/4	0/1	0/1	0/1					0/1	
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/4	0/1	0/1	0/1					0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/4	0/1	0/1	0/1					0/1	

Comments: a. through d. Based on the documents the Center submitted in response to the document request, four of the individuals whom the Monitoring Team members responsible for the review of physical health reviewed had experienced dental refusals in the past twelve months. The respective IDTs had not developed specific goals/objectives related to any of these refusals. Per the documentation submitted for review, concerns with the lack of goals/objectives included the following:

- Individual #7 had two refusals in the past 12 months, including a refusal on 10/1/18, because she did not want to leave work, and another refusal to attend dental clinic on 12/12/18.
- Individual # 389 refused a dental clinic appointment on 10/29/18, and several later dental notes (i.e., 1/30/19, 2/5/19, and 2/19/19) documented that he continued to be uncooperative. The dental note for his annual exam, on 2/5/19, indicated declining cooperation in the past year and suggested that the dentist would need to discuss sedation with the IDT if refusals continued. On 2/19/19, a dental note documented initiation of consent for TIVA. It was concerning that it did not appear dental staff discussed whether oral sedation might be an option.
- On 2/5/19, Individual #346 refused an off-campus appointment. He also missed two clinic appointments in March 2019, although the documentation did not state whether these were refusals or resulted from some other issue(s).
- On 5/20/19, Individual #362 refused his dental appointment because he wanted to go to work. Based on dental notes reviewed for the past twelve months, he also refused dental appointments on 9/6/18 and 1/18/19.

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: Work is still needed to improve the clinical relevance and measurability of goals/objectives. It also 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	7	389	346	400	215	357	255	362	226
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	25% 3/12	0/3	0/1	0/1	2/2	0/1	1/2	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	25% 3/12	0/3	0/1	0/1	2/2	0/1	1/2	0/1		0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	17% 2/12	0/3	0/1	0/1	2/2	0/1	0/2	0/1		0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	8% 1/12	0/3	0/1	0/1	1/2	0/1	0/2	0/1		0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	9% 1/11	0/3	0/1	0/1	1/1	0/1	0/2	0/1		0/1

Comments: a. and b. Individual #362 had functional communication skills. Six of the remaining eight individuals did not have clinically relevant, achievable, and measurable goals/objectives that were included in their ISPs/ISPAs. The goals/objectives that were clinically relevant and measurable, as well as included in the ISP, were for those for Individual #400 (i.e., request preferred edible or drink, and choose between snack items), and one of the goals/objectives for Individual #357 (i.e., imitate a word/sign).

Overall, clinicians continued to need to address communication by conducting quality assessments, and making recommendations to the program writers and the IDT with regard to communication-related goals that are based on the individual's strengths and needs. In many cases, the Speech Language Pathologists (SLPs) merely addressed the Communication Dictionary and communication strategies rather than discuss and make recommendations related to specific communication needs in the implementation of behavior support plans, skill acquisition plans (SAPs), and specific communication goals. SLP participation via the assessment and in the development of supports is vital to ensuring that communication strategies are consistent, that AAC devices and other strategies are recommended, as appropriate, and are well integrated into individuals' programming, and that the clinicians are able to track the effectiveness of supports throughout the year rather than primarily at the time of the annual assessment.

c. through e. QIDP reviews often did not include specific data, or analysis of data, reflective of individuals' goals/objectives. The exceptions were for both of Individual #400's goals/objectives. It was good to see that Individual #400 had made progress on one of his goals (i.e., request preferred edible/drink), and that the IDT took needed action when he did not make progress on the other (i.e.,

choose between snack items).

As noted above, Individual #362 had functional communication skills, but was part of the core group, so a full review was conducted for him. For the remaining eight individuals, the Monitoring Team also completed full reviews due to a lack of clinically relevant, achievable and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives, or a lack of progress.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.

Summary: It was good to see that IDTs had documented implementation of the measurable communication strategies and action plans that had been included in individuals' ISPs. Still as described above, it remained concerning that IDTs did not integrate, and therefore did not implement, many of the recommended strategies and action plans. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	7	389	346	400	215	357	255	362	226
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	50% 2/4	N/A	N/A	N/A	2/2	N/A	0/2	N/A	N/A	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	100% 2/2	N/A	N/A	N/A	2/2	N/A	N/A	N/A	N/A	N/A

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not IDTs implemented measurable strategies related to communication. While it was positive that the QIDP Monthly reviews evidenced implementation for the goals/objectives for Individual #400, it remained concerning that IDTs did not incorporate or implement many of the recommended communication strategies into other individuals' ISPs, as described with regard to Outcome 1 above.

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

Summary: The Center should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, 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	7	79	281	121	258	331	24	352	335
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	67% 8/12	1/2	1/1	1/1	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.	42% 5/12	1/2	1/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1
			Individuals:								
#	Indicator		363	230							
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	0/1							
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/1	0/1							
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	N/R									
Comments: a. and b. Based on observations, it was concerning that many individuals were not using AAC devices in a functional manner, and staff were not facilitating their use. In addition, AAC devices that individuals were supposed to use at the work site were not consistently readily available or being offered.											

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. For this review, one additional indicator was added 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.

At the time of the last monitoring visit, the Center did not have any transitions to review, but the pace of transition activity had picked up considerably since then.

It was good to see that transition staff and IDTs were meeting regularly to discuss transitions and identify and address any barriers.

Transition staff reported they were focusing heavily on improving the development of measurable supports and pre-move training and competency testing. The Monitoring Team agreed these were priority areas, along with the need to focus on ensuring that the IDTs developed a comprehensive set of needed supports. In particular, we recommended they focus on several key areas: behavioral needs, health and safety concerns, and meaningful day activities time (including both employment and activities that promote community engagement).

Overall, the Post Move Monitor was diligent when reviewing whether providers were delivering supports as required, but still needed to engage the IDT members to help determine when follow-up actions might be needed. For example, when an individual becomes ill after transition takes place, the PMM should bring this to the attention of the IDT, so that the members might weigh in on whether that illness might have been attributable to a lack of provider knowledge or competence in providing care, or perhaps prompt advice for the provider to address, resolve, and/or prevent recurrence the situation.

Seven-day post move monitoring was observed at an individual's day program and home. The PMM was thorough in going through each support, one by one. He interviewed staff at the home, but not at the day program. Overall, there was good improvement in post move monitoring.

One of the individuals had a PDCT arising from an episode of lithium toxicity. It was good to see the IDT recognized this might have been preventable if they had developed training and supports for provider knowledge with regard to signs and symptoms

of potential side effects of the individual's medications. It was also good to see transition staff had already begun working with nursing staff to ensure that signs and symptoms would be more thoroughly addressed in future CLDPs.

The Monitoring Team once again wanted to raise a concern about the need for supports surrounding the very specific and rigid monitoring protocols required for individuals receiving Clozaril. Both individuals were subject to these requirements. While their CLDPs included supports for certain pieces of the protocol, they did not provide a clear and comprehensive set of required actions and provider staff knowledge. State Office may want to provide some guidance with regard to required content for CLDP supports for such individuals.

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: At the last review, there had been no transitions and, therefore, no review by the Monitoring Team. Therefore, it was good to see that the Center had moved forward and made progress with many areas of transition planning, especially within this outcome. Thus, though the overall scores are 0%, there was some positive scoring on some sub-indicators. This is detailed in the comments below. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	205	109							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments: Five individuals transitioned from the Center to the community since the last monitoring visit. The Monitoring Team selected two of the transitions (Individual #205, Individual #109) for review. Both individuals transitioned to a group home that was part of the State's Home and Community-based Services (HCS) program. The Monitoring Team reviewed these two transitions and discussed them in detail with the San Antonio SSLC Admissions and Placement staff while onsite. At the time of the last monitoring visit, the Center did not have any transitions to review, but the pace of transition activity picked up considerably since then. It was good to see that transition staff and IDTs were meeting regularly to discuss transitions and identify and address barriers.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. Transition staff reported they were focusing heavily on improving the development of measurable supports and pre-move training and competency testing and the Monitoring Team agreed these were priority areas. To move toward compliance, the IDTs should continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) can accurately judge implementation of each support. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed 12 pre-move supports for Individual #205 and eight pre-move supports for Individual #109. Some supports focused on health care actions to be taken prior to the transition and ensuring the presence of needed assistive equipment and/or the delivery of needed supplies. These pre-move supports were typically measurable. Other pre-move supports called for pre-move training for provider staff across several areas of need. To achieve compliance in this area, the Center must describe how it will verify that provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. Pre-move training supports should address the content of provider staff training as well as describe the staff to be trained, the training methodologies to be used, the competency criteria and how competency will be measured. As the following examples demonstrate, some progress was noted, but overall the pre-move training supports did not yet fully meet criterion for measurability for either individual:
    - The CLDP for Individual #205 included three pre-move supports for provider inservice training (i.e., dining plan needs, communication strategies and behavioral prevention strategies). These supports typically indicated which provider staff needed to be trained, which was positive. Two of the pre-move training supports (i.e., dining plan needs and behavioral prevention strategies) also specified the competency criteria, which was also positive, but the support for training on communication strategies did not.
    - For Individual #109, the CLDP included one pre-move training support for his behavioral needs. The support described which staff would require training and provided a list of topics to be covered (i.e., targeted behaviors including SIB and disruptive behavior, precursors, prevention strategies, and responding to targeted behavior). The support did not describe the specific competency criteria needed to confirm essential staff knowledge of these topics.
    - The CLDPs for both individuals included a pre-move support calling for the Center's Registered Nurse Case Manager (RNCM) to complete a nurse-to-nurse report with the provider nurse. The support listed topics, but did not consistently specify the competency criteria.
    - Supports for both individuals generally described the training methodology to be employed, which was good to see; only Individual #205's support for dining needs did not.
        - It was especially good, though, to see that Individual #205's pre-move behavioral training support specified that modeling and role-playing would be included in the teaching methodologies.
    - For both individuals, the Monitoring Team also reviewed documentation related to the pre-move training and found that quizzes generally were brief and did not test provider staff knowledge of all competency criteria as specified in the supports or of some other important needs. In other words, the quizzes did not serve to measure whether needed pre-move competencies were in place. Specific concerns with regard to competency testing are discussed further in Indicator 14 below.

- Post-Move: The respective IDTs developed 42 post-move supports for Individual #205 and 36 post-move supports for Individual #109.
    - For both individuals, many of the post-move supports were measurable and specified several types of evidence needed to confirm their presence. This was positive, but not yet consistent. For example, post-move training supports typically reflected the same presence or lack of measurable competency criteria as found in the related pre-move supports.

- In addition, as described further below in Indicator 2, neither of these individuals had a post-move support that clearly identified the requirements of the Clozapine monitoring and dispensing protocol, the parameters for results of monthly CBCs or who would be responsible for monitoring those. This was an oversight with potentially significant impact and is discussed further below in Indicator 2.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. Still, neither of these CLDPs fully addressed support needs in a comprehensive manner and did not meet criterion, as described below. The Monitoring Team recommended Center staff focus efforts on several key areas: behavioral needs, health and safety concerns, and meaningful day activities, the latter including both employment and activities to promote community engagement and integration.

- Past history, and recent and current behavioral and psychiatric problems: Individual #205's CLDP demonstrated some improved practices in this area, which was positive. To achieve criterion, the IDTs should continue to make improvement toward developing comprehensive supports to address behavioral and psychiatric needs and to ensure provider staff have a sufficient understanding of behavioral history. Findings included:
  - Based on review of the documents provided, Individual #205's CLDP included a pre-move support for provider staff training that thoroughly described her behavioral support needs and included strategies related to known historical behaviors.
  - Individual #109's behavioral assessment (BHA) documented a long history of behavioral and psychiatric problems, including the following: rage, aggression, homicidal ideation, psychiatric hospitalizations, feigned auditory hallucinations, and suicidal ideation. The BHA also described an attempt by Individual #109 to access material about sexual violence toward women. The CLDP included a pre-move support for provider staff training that referenced broad topics to be addressed (i.e., targeted behaviors of self-injury and disruptive behavior, precursors, prevention strategies, and responding to targeted behaviors), but the support did not indicate that these historical issues would be covered or provide any other details. The post-move supports for ensuring provider staff could meet Individual #109's behavioral needs only indicated that the provider would train any staff working with him, but they required use of the Center's training, which did not reference the history.
  - As described above, Individual #109's pre-move training competency testing did not specifically address the need for staff knowledge for a number of behavioral needs or strategies, and his post-move behavioral supports also did not describe the specific details of his behavior support requirements.
  - Both individuals were prescribed Clozapine, a psychotropic medication for which a specific protocol is required for monthly CBC monitoring of the individual's absolute neutrophil count (ANC). This protocol is known as the Clozapine Risk Evaluation and Mitigation Strategy (REMS). This is required due to an elevated risk for serious, life-threatening infection associated with the medication's administration. Due to the significant risk for harm, only accredited physicians can prescribe the medication, and only enrolled pharmacies are allowed to dispense. For both individuals, their respective assessments and the CLDP narratives noted how important it would be for the individual to continue to receive the medication, but neither CLDP developed supports that clearly laid out the REMS procedures, the parameters by which the monthly CBCs would be assessed, or describe who would be responsible for monitoring them.

As the Monitoring Team has pointed out, it is essential that this protocol be clearly described in both pre-and post-move supports, and that staff knowledge be confirmed. The respective CLDPs did not do so.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed some good supports related to safety, medical, healthcare, therapeutic, and risk needs, such as for scheduling of health care appointments, but this was not consistent. To meet criteria, the IDTs still needed to develop comprehensive and cohesive supports. For example:
  - The CLDPs for both individuals did not describe the potential side effects of the individuals' medications that needed to be monitored or ensure provider staff knowledge.
  - Both individuals required weekly weights, but the CLDP supports did not provide any information about why this was necessary, how the weights should be monitored or by whom, or what actions staff needed to take based on weight loss or gain.
  - While both CLDPs included a nurse-to-nurse consult to cover several topics (e.g., how their medications should be administered and Individual #109's signs and symptoms for gastroesophageal reflux seizures and constipation), neither required that direct support staff have knowledge of any of those topics.

- What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Neither CLDP identified or addressed important outcomes in an assertive manner. For both individuals, the IDTs cited limited and broad important outcomes that were not individualized overall. Both indicated the primary outcomes were to successfully transition and acclimate to the new environment. Individual #205's CLDP did not include any other specific outcomes, such as being able to maintain her relationship with her mother, which the profile and various assessments indicated was important. While Individual #109's CLDP did broadly indicate he would like to obtain a job in the community, the IDT not develop clear outcome-oriented supports in that area, as described further in the next set of bullets.

- Need/desire for employment, and/or other meaningful day activities: Neither CLDP assertively addressed individuals' needs and preferences in this area and did not meet criterion:
  - Per Individual #205's vocational assessment, she possessed many vocational skills (e.g., independently performed most workroom activities and followed through with her schedule, usually on an independent basis) and was motivated by earning money (e.g., would sign work followed by the sign for money). The CLDP supports did not address opportunities to perform work and earn money, which she had been able to do at the Center. Instead, the IDT only developed supports that she be provided with a choice of activities daily when attending the day program and to have a day programming assessment within 30 days.
  - For Individual #109, the CLDP did not define an employment outcome. At the Center, he was working as laundry assistant and making minimum wage, and the pre-CLDP discussion indicated obtaining a job coach within 60-90 days would be important. At the CLDP, the IDT further discussed that he would need an application for the Texas Workforce Commission (TWC) because he was under the age of 24. The Center vocational manager noted Individual #109 had previously received the required career counseling, but did not say when that had occurred or provide any details in the vocational assessment. The provider then requested a copy for the purpose of facilitating the process of obtaining

job coach. The IDT created a pre-move support to provide the requested copy, but no post move supports for obtaining a job coach or requiring a referral to the TWC. Instead, the IDT developed two supports, one to attend day programming and another to have a vocational assessment within 30 days. It was unfortunate that the latter support did not require that any additional action be taken based on the assessment results.
    - The CLDPs for both individuals also did not assertively address meaningful day activities in the community. For example, Individual #205 had an ISP goal to volunteer at a specific community event (i.e., a local marathon), which would have continued to be a good opportunity for promoting community integration after the transition occurred. Similarly, her ISP included an action plan to participate in a monthly bingo event at a local church where she might meet peers from the community. The IDT did not address these opportunities or others that may have allowed her to develop friendships in the community.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success: For Individual #205, it was good to see the IDT developed supports with regard to specific reinforcement protocols, but Individual #109's CLDP did not include such supports.

- Teaching, maintenance, participation, and acquisition of specific skills: Based on their needs, the CLDP for these two individuals did not fully address needs in this area.
    - Individual #205's CLDP did not include any supports in this area. In her ISP, the IDT had identified a need for training with regard to pedestrian safety and shopping for her own clothing, both of which would have been very appropriate skills to continue in the community.
    - At his request, Individual #109's CLDP did include a support for preparing his own lunch daily, which was positive. His IDT identified additional opportunities for skill development, such as choosing and planning activities and self-advocacy, consistent with his vision statement's emphasis on skills development in the areas of time management and developing/adhering to a more stable daily routine. Community living should offer enhanced opportunities to practice and engage in such skills, but the CLDP included only one related support, and it would have been satisfied if he participated in choosing and planning an outing just once per month. Going forward, it will be important for the IDT to consider how to translate the vision and goals developed by the IDTs into meaningful day-to-day routines that would realistically provide enough opportunity to support learning and skill acquisition.

- All recommendations from assessments are included, or if not, there is a rationale provided: Overall, San Antonio SSLC had a good process in place for documenting discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional, recommendations. To continue to move toward compliance, CLDPs should provide a clear justification when it declines to include recommendations from any discipline assessment. This justification should not be based on the provider's assertion that it has mechanisms in place to meet the support, however. For example, Individual #205's IDT agreed to remove the Center's psychiatrist's recommendation that Individual #205 would need follow-up with a psychiatrist who could prescribe and follow the Clozapine prescription, and provided as justification a statement that the provider currently contracted with such a physician. IDTs should be sure to fully describe the individual's support needs and how they will be met, whether or not the provider currently has the capacity to meet them.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: Post move monitoring was occurring as required and continued to improve in quality and documentation, though further work was needed to get to criterion for these indicators. In particular, supports needed better definition of what should be monitored by the PMM, however, the PMM also needed to continue to improve the depth of his monitoring, documentation, and referral of information back to the IDT. The Monitoring Team continued to be impressed with the PMM's continued improvement in post move monitoring and receptivity to feedback. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	205	109								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1								
6	The PMM's assessment is correct based on the evidence.	0% 0/2	0/1	0/1								
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	0% 0/1										
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1										
Comments: 4. The PMM Checklists did not consistently provide valid and reliable data. The PMM included comments regarding the provision of every support, which was good to see, but these sometimes did not include sufficient detail to reliably ascertain whether the supports were implemented as required. In some supports, the language was broad and vague, as described in Indicator #1. But, in addition, the PMM did not consistently address all aspects of the supports. For example, Individual #109's CLDP included two post-move supports for provider staff to be trained regarding his behavioral prevention strategies and precursors, but at the time of the 45-day PMM visit,												

the PMM only documented interviewing staff about precursors and did not reference the topic of behavioral strategies. To continue to move toward compliance, the Center should work toward improving overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports and the PMM should consistently provide comments that all required evidence has been reviewed, or otherwise document a valid reason why this was not needed or did not occur.

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

- For Individual #205, the PMM largely indicated supports were in place as required, but did not always provide documentation that would confirm this was so, as described below in Indicator 6.
- For Individual #109's seven-day PMM visit, the provider had not ensured implementation of several supports, including:
    - He had not been brushing his teeth twice daily and no evidence indicated that staff knew they were supposed to prompt him to do so.
    - Provider staff were not aware of his precaution for remaining upright after meals. As a result, he had experienced an episode of vomiting after laying down too soon after the evening meal.
    - Lead provider staff on the home did not have knowledge of his SAMS training.
    - The provider had not included Ensure on his daily checklist; thus, there was no evidence it had been provided.

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

- As one example, neither CLDP included a post move support for the PMM to check staff retention of knowledge with regard to behavioral strategies; rather they only required that the provider would inservice any new staff. In that case, the PMM Checklist indicated "staff interview" would be required, but didn't state which staff or describe the competencies they would need to demonstrate. In both instances, the PMM marked the support as in place (i.e., inservice of new staff), but both should have been marked NA.
- In some other instances, the PMM did not provide sufficient documentation to substantiate the affirmative score. For example, the PMM indicated a support was in place for Individual #205 to have a haircut based on the provider's email message that she would be going to get a haircut that weekend. The PMM should not score supports in place based upon the provider's plan to implement them, but rather on whether they have been implemented as specified.
- In another instance, the PMM determined that a support for Individual #205 to walk three times per week was in place. The evidence provided indicated provider staff said they offered her the opportunity, but she sometimes declined to go. Since the purpose of the support was related to her health care needs for exercise, this should have been marked as not in place and referred to the IDT for follow-up.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. In addition, it is important for the PMM to engage the IDT with regard to findings that may require discipline-specific knowledge to interpret. The Center did not have a protocol in place for engaging the IDT, but should consider establishing one. The Monitoring Team requested any documentation the Center kept that IDT

members were informed of PMM findings, but the Center indicated it had no evidence to provide. The following are examples of concerns that should have prompted IDT engagement:

- At the time of Individual #205's 45-day PMM visit, the PMM documented that she had been diagnosed with a UTI and possible renal dysfunction. The community PCP prescribed antibiotics and planned to complete additional labs after that course of medication was completed, ostensibly to follow-up on the renal dysfunction. This should have prompted the PMM to contact the IDT to obtain the input of appropriate disciplines. The PMM could not be expected, especially in the absence of CLDP supports that described side effects to monitor, to recognize that renal dysfunction could be related to elevated lithium levels, but the medical and nursing staff on the IDT could possibly have identified this in a timely enough manner to minimize possible negative impacts.
- At the time of the seven-day PMM visit on 5/22/19, the PMM documented that the provider had weighed Individual #205 that day with a result of 175 pounds. This was approximately 13 pounds less than the weight of 188 pounds reported in the nutrition discharge assessment. While it was possible this discrepancy was attributable to a different weighing protocol (e.g., weight scale, clothing, etc.), it was significant enough to require follow-up with the IDT to consider if any action might be needed. At the time of the 45-day PMM visit, the provider documented Individual #205 had had lost another nine pounds in approximately three weeks between 5/22/19 and 6/13/19. While Individual #205 was on a weight reduction diet, her nutrition assessment indicated her weight trend had been stable or increasing and, further, that her goal was to lose one to two pounds per month. Consequently, a weight change of this magnitude should have prompted the PMM to seek IDT input.
- Similarly, the PMM documented that he reviewed Individual #109's CBC results, but did not provide any indication of what the results showed. The CLDP did not provide any specificity about the CBC parameters that might indicate a problem with regard to his Clozaril prescription, so it was unclear the PMM had the necessary knowledge to evaluate those results and determine if a problem existed and/or follow-up action was needed.

9-10. While onsite, the Monitoring Team accompanied the PMM to visit with Individual #205, who was receiving treatment in a long-term care facility following a Potentially Disrupted Community Transition (PDCT) event, as described below in Outcome 3. No decision had been made about where she might reside in the future. The PMM did not complete a full Checklist, but rather attempted to determine her current status and possible discharge plans. This was complicated by the long-term care facility's protocols for release of information and seeming reluctance on the part of Individual #205's mother to agree to having information shared with the PMM. As a result of these circumstances, these indicators were not rated for Individual #205. Overall, it was good to see that Individual #205's health had improved from what was reported to have been her condition a few days earlier.

The Monitoring Team also accompanied the PMM on the seven-day post move monitoring visit to the day program and home of Individual #360. She attended a local day habilitation program. During the observation, 1:30 pm, there were no activities occurring. Individual #360 and the other individuals were sitting at tables in three or four classrooms. Likely, a more engaging day will be needed for Individual #360 to continue to be successful in the community. The PMM talked with some staff about Individual #360 and also talked with management staff. It would be better for the PMM to take a few minutes interviewing specific direct staff member(s), if supervision of individuals could be handled by day hab management. The home, run by Premiant, was a nice house and Individual #360 appeared to be very comfortable there. The PMM was able to conduct a thorough interview of the one staff member present because Individual #360 and her one housemate were engaged, watching TV in the living room. The staff member was extremely knowledgeable of Individual #360, her supports, and her needs, even though she had only moved in a few days prior. The PMM went

through the list of CLDP supports one by one. He asked for, and was able to review, the post move monitoring checklist, which was completed correctly and up to the current time period, too. Individual #360 set the table and the individuals were given a very nice fish and vegetable dinner.

Other than conducting a more thorough, detailed interview of at least one direct care staff member at the day program, the PMM met criteria with indicator 9. The written report was an accurate reflection of what the Monitoring Team observed during this post move monitoring visit (indicator 10).

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

Summary: Individual #109 had no PDCT events, which was good to see. On the other hand, Individual #205 had a serious PDCT event (lithium toxicity) that left her in a long-term care facility at the time of this onsite visit. The Center, however, did a good review of what supports should have been in place to have reduced the likelihood of this incident. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	205	109							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	0/1	1/1							

Comments:

11. Individual #109 had not experienced a PDCT event. Individual #205 had been hospitalized with lithium toxicity on 7/1/19 and at the time of this monitoring visit, had been transferred to a long-term care facility. The Monitoring Team accompanied Center staff to visit Individual #205 at the long-term care facility and it was good to see that she appeared to have made a significant recovery since her admission there.

In discussing this event at a PDCT ISPA, it was positive Center staff had identified some actions they could have taken prior to the transition, but did not, that may have helped to prevent this PDCT event. The IDT concluded they had not emphasized education and training to direct care staff on side-effects and signs to monitor for lithium or written a related support in the CLDP, but should have.

While it was good the IDT recognized the need for staff to recognize and monitor side effects of lithium (e.g., renal complications), the Monitoring Team noted the IDT should have further considered that it was also incumbent on them to identify appropriate preventative measures. For example, dehydration can contribute to the potential to develop lithium toxicity. Per the nutrition assessment recommendation, provider staff needed to ensure adequate hydration of at least 60 oz of fluid daily. At the CLDP, the IDT decided not to include a support for tracking fluid intake, instead citing Individual #205's ability to request or obtain fluids on her own and noting that she usually either had a bottle of water with her or would use the water fountain. Still, the IDT appeared to acknowledge that a water

fountain might not be readily available in a community environment and suggested the provider might need to encourage Individual #205 to use a re-usable water bottle and to be reminded not to throw it away. The IDT did not develop any CLDP supports for providing a re-usable water bottle or encouraging its use, or for general staff knowledge of her need for hydration.

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

Summary: This outcome addresses many different transition planning activities. Overall, there was progress and 100% was scored for three of the indicators. Indicator 18 sustained this high performance and, therefore, this indicator will be moved to the category of requiring less oversight.

Even so, the detailed comments below point to some areas in need of improvement, including ensuring that the individual indeed wants to move, and provider staff training is complete and competency-based. These indicators will remain in active monitoring (other than indicator 18).

#	Indicator	Overall Score	Individuals: 205	109							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	50% 1/2	0/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	100% 2/2	1/1	1/1							

17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	100% 2/2	1/1	1/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments:

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

- Assessments updated with 45 Days of transition: Overall, disciplines provided assessments for the CLDP and consistently met criterion for timeliness, which was positive.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: IDTs still needed to ensure that assessments were comprehensive in scope and reflected current status. For example, as previously reported, the psychiatric assessments were very brief and provided little information. In addition, for these two CLDPs, the narratives indicated the most recent QDRRs had been reviewed by the IDT, with no changes needed, but it did not describe that baseline information.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not yet thoroughly provide recommendations to support transition. At the time of the last monitoring visit for which the Monitoring Team reviewed transitions, transition staff reported they had been working with some disciplines on an individual basis to review and refine recommendations, which was positive, and were currently continuing to do so.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Assessment recommendations varied considerably in comprehensiveness and individualization. For example, the FSA summaries tended to indicate that most skill acquisition plans would be discontinued because they would not be appropriate for implementation in the community, but failed to recommend other more appropriate skills based on her needs. Given that FSA tool includes community living items, the assessment should have focused at least some attention on recommendations based on findings from that section.

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

One of two CLDPs met criterion for this indicator. Based on a review of the documentation submitted for Individual #205, the IDT did not describe how they reviewed the CLDP and the transition decisions with her. Documentation for each ISPA for transition-related meetings, as well as for the CLDP meeting, indicated she did not attend. The Monitoring Team requested any other documentation (e.g.,

QIDP monthly reviews) to show how the IDT shared all that decision-making with her or otherwise factored in her input. The Center indicated it had no additional documentation. This was even more concerning because the pre-move ISPA documentation appeared to show she may have not been comfortable with the move. For example, ISPA documentation, dated 2/5/19, noted that the IDT thought the setting appeared to be a good fit, but also indicated it took her several days to de-escalate after her most recent visit. The IDT did not document any further discussion about what that might mean in terms of her adjustment or how it might reflect upon her preference for the setting. On 2/14/19, the provider reported that Individual #205 did not appear to want to be at the home and recommended a different home. While the IDT suggested it could be expected they might see some old behaviors (e.g., incontinence) resurface with the transition, the provider continued to express that Individual #205 wasn't happy. The IDT then decided to attempt another visit. The next ISPA on 3/20/19 indicated she had done better on that visit, but was still resistive and said she wanted to go home. The IDT then finalized the provider selection.

The Monitoring Team attended the CLDP meeting for Individual #361. The Monitoring Team did not review her case or her particular supports. Her meeting was well-attended by SSLC staff and clinicians, including the PCP and psychiatrist. Individual #361 actively participated in the meeting, as did the SSLC staff and provider. This was a very positive meeting in terms of participation and discussion.

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

- The IDTs inconsistently identified the expected provider staff knowledge or competencies that would need to be demonstrated. It was positive that some supports clearly defined criteria that would demonstrate provider staff were competent to provide for the individuals' health and safety needs, but this was not yet consistent.
- To continue to move toward compliance, the Center should ensure its written exams are constructed to cover all essential knowledge. The testing materials reviewed by the Monitoring Team fell short of this mark. Competency testing did not clearly document provider staff had knowledge of all essential supports based on each individual's needs. Most competency quizzes probed only a very small number of the many specific needs and supports for each individual. Examples included:
    - Although Individual #205's behavioral pre-move training support specified detailed competency criteria, the nine-question competency quiz did not address these in a thorough manner. For example, the quiz required staff to name only one of her targeted behaviors, while the support indicated she had three (SIB, disruptive behavior, and aggression).
    - The completed competency quizzes reflected a lack of provider staff competency or basic understanding of her behavioral strategies. Based on the documentation reviewed, there was no evidence responsible Center staff recognized this lack of competency or acted to provide needed re-training prior to the transition. The following provides some examples of questions and incorrect responses that Center staff did not address:
        - In response to a question asking for provider staff to state the function of one of her behaviors, one staff answered that the function of hitting (i.e., aggressive behavior) was biting her hands. Another indicated that the function of disruptive behavior was yelling and cursing at staff.
        - The quiz posed a question with regard to one of the first things provider staff should do in the event of self-

injurious behavior. Provider staff gave inconsistent, contradictory, and often incorrect responses (e.g., "ignore completely and do not redirect in any way;" "count and make sure she doesn't hurt herself and call nurse;" "leave her alone at first, then call her name while getting eye contact").

- For Individual #109, the pre-move training support for behavioral supports listed topics instead of competency criteria. The quiz Center staff administered consisted of just six questions and these did not fully address his behavioral needs and strategies. For example, similarly to the quiz for Individual #205, this quiz required only that provider staff be able to identify one of his two target behaviors (i.e., self-injurious behavior and disruptive behavior). In addition, the quiz devoted two of the six questions to provider staff knowledge of his level of intellectual disability and to their ability to name one of his psychiatric diagnoses. It is questionable whether this knowledge alone would be valuable without also testing staff's ability to articulate the related impact, if any, on his behavior and the appropriate strategies with which to respond.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any were completed, summarize findings and outcomes. It was positive that both CLDPs included a requirement for nurse-to-nurse collaboration and listed topics. For the future, it will be important for the IDT to also document that it considered any other collaborations that might be needed and why it made those determinations. For instance, for both of these individuals, who were subject to the REMS protocol for Clozaril and for whom the IDT emphasized how important continuation of the medication will be, the CLDP should have reflected that the IDT considered whether a psychiatrist-to-psychiatrist collaboration might be needed.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. The CLDPs for both individuals indicated the IDT considered whether a settings assessment was required and determined it was not. This appeared to be accurate, but the IDTs should be cautious in the future about limiting settings considerations to whether individuals have mobility concerns, which was the only factor these CLDPs referenced.

17. The CLDP should include a specific statement of the IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. CLDP documentation described some positive practices implemented for both transitions, including that DSPs spent time at the respective group home during dinner visits. For the future, it will also be important for the IDT to specify the purpose or intent of the DSP activity, as well as how DSP feedback would be integrated in the transition planning process.

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

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. This was positive, but timeliness is only one component of compliance for this indicator. It is also essential the Center can directly affirm provider staff competency to ensure health and safety prior to relinquishing day-to-day responsibility. The PMSRs for these two individuals did not accomplish this. The CLDP included numerous pre-move supports for training, but these did not meet criterion for ensuring that

provider staff were competent for either individual, as described above with regard to Indicator 14.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: There were ongoing activities occurring regarding both transitions even though both took longer than 180 days. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	205	109								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 2/2	1/1	1/1								
Comments: 20. These two CLDPs met criterion for this indicator. While both exceeded 180 days, transition logs documented ongoing activity on the part of Center staff to identify available community settings appropriate to the individuals' needs and to identify and address barriers.												

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.
- QAQI Council (or any committee that serves the equivalent function) minutes (and relevant attachments if any, such as the QA report) for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.
- The facility's own analysis of the set of restraint-related graphs prepared by state office for the Monitoring Team.
- The DADS report that lists staff (in alphabetical order please) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- A list of any individuals for whom you've eliminated the use of restraint over the past nine months.
- A copy of the Facility's guidelines for assessing engagement (include any forms used); and also include engagement scores for the past six months.
- Calendar-schedule of meetings that will occur during the week onsite.

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

APPENDIX B - List of Acronyms Used in This Report

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

HCS	Home and Community-based Services
HDL	High-density Lipoprotein
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
SUR	Safe Use of Restraint
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus