United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

Dates of Onsite Review: January 4-8, 2016

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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. The amount of documentation requested by the Monitoring Teams decreased with the changes in the way monitoring was being conducted.
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. **Scoring** – The 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. The parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews. Therefore, none of the figures in this report should be construed as a statement regarding the Facility's compliance with the Settlement Agreement.

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. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
d. **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.
e. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
			Individuals:								
#	Indicator	Overall Score	147	313	35	2	176				
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	50% 6/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	20% 1/5	0/1	0/1	1/1	0/1	0/1				

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (March 2015 through November 2015) were reviewed. The data showed that the overall use of crisis intervention restraint at Lufkin SSLC occurred from around 25 times to 65 times each month and over the nine-month period, was not showing an overall decrease (though the last three months of the graph showed a large decrease). Moreover, the census-adjusted frequency of restraint usage at Lufkin SSLC was the fifth highest in the state.

The data for the use of physical crisis intervention restraints somewhat paralleled the overall use of crisis intervention restraints, though the average duration showed a decrease over the period. Crisis intervention chemical restraints were rarely used, but their frequency showed an upturn in the most recent three months. Mechanical crisis intervention restraints were rarely used and were at a very low rate, that is, only one time in the nine-month period.

Injuries resulting from the usage of restraint were increasing, though it might be helpful to separate out serious from non-serious injuries. The number of individuals who received crisis intervention restraint was not decreasing; it ranged from 11 to 23 individuals each month. The number of individuals who had protective mechanical restraint for self-injurious behavior, however, was very low (one); this was a strength at Lufkin SSLC, that is, working with individuals to reduce the need for protective mechanical restraint for self-injurious behavior.

Restraints for dental procedures were at a low level, as were non-chemical restraints for medical procedures. The use of chemical restraint for medical procedures, however, was increasing.

Thus, state and facility data showed low usage and/or decreases in six of these 12 facility-wide measures (i.e., duration of physical restraints, use of mechanical crisis intervention restraints, use of protective mechanical restraint, use of chemical or non-chemical

dental restraints, use of non-chemical medical restraints).

The director of behavioral health services maintained a set of data graphs to help her manage the use of restraint at Lufkin SSLC. This was good to see. Inclusion of the additional data sets described above may also be of value to her.

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. All five received crisis intervention restraints (Individual #147, Individual #313, Individual #35, Individual #2, Individual #176). Data from state office and from the facility showed decreases in frequency or very low occurrences over the past nine months for one (Individual #35).

The other four individuals did not have any occurrences of crisis intervention restraint or protective mechanical restraint for self-injurious behavior. The Monitoring Team looked to see if any of these individuals had any restraints in the nine-month period preceding the nine-month period reviewed (i.e., June 2014-February 2015). If so, they would then be included as an individual who had shown progress in the reduction of restraint occurrences. None of these four individuals had restraint in that prior nine-month period and, therefore, none were included in this indicator.

The facility reported that five other individuals no longer needed to have protective mechanical restraint for self-injurious behavior. This demonstrated good progress for those individuals, and positive results from focus by the behavioral health services department, IDTs, and others.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.

			Individuals:								
#	Indicator	Overall Score	147	313	35	2	176				
3	There was no evidence of prone restraint used.	100% 9/9	1/1	2/2	2/2	2/2	2/2				
4	The restraint was a method approved in facility policy.	100% 9/9	1/1	2/2	2/2	2/2	2/2				
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 9/9	1/1	2/2	2/2	2/2	2/2				
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 6/6	N/A	2/2	2/2	2/2	N/A				
7	There was no injury to the individual as a result of implementation of the restraint.	78% 7/9	1/1	2/2	1/2	1/2	2/2				
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 9/9	1/1	2/2	2/2	2/2	2/2				
9	There was no evidence that the restraint was used in the absence of,	57%	0/1	2/2	Not	0/2	2/2				

	or as an alternative to, treatment.	4/7			rated						
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 9/9	1/1	2/2	2/2	2/2	2/2				
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	56% 5/9	1/1	0/2	2/2	0/2	2/2				

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for five different individuals (Individual #147, Individual #313, Individual #35, Individual #2, Individual #176). Of these, seven were crisis intervention physical restraints, and two were crisis intervention chemical restraints. The crisis intervention restraints were for aggression to staff or peers, and/or property destruction. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

5. For two restraints (Individual #147 10/8/15, Individual #176 9/8/15), it was not evident in the restraint documentation that there was an immediate and serious risk of harm. The Monitoring Team reviewed the facility's onsite submission of the staff observation notes from those days. The notes supported that there was an immediate and serious risk of harm. Therefore, these two restraints were scored as meeting criterion for this indicator. Even so, the facility needs to ensure that adequate substantive information is always included in the restraint checklist. The facility also reported that both occurred during the time the behavioral health services director, who does quality assurance on all restraint documentation, was not available. This was discussed onsite and will likely be corrected for the future.

7. Injury was recorded as occurring for two restraints. Neither were serious.

9. Because criterion for indicator #2 was met for Individual #35, this indicator was not scored for him. For Individual #147, a PBSP was not in place, and for Individual #2, some medical issues remained unresolved that could have contributed to behaviors that led to restraint (e.g., blood sugar).

11. The IRRF section of the ISP did not show a selection of one of the two options in the template to document restraint considerations for two of the individuals. This clerical task should be easy to correct for all individuals.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	147	313	35	2	176				
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	60% 3/5	1/1	1/1	1/1	0/1	0/1				

Comments:

12. Individual #2's staff, even with many prompts, could not name prone as prohibited restraint. The staff was not sure if any restraints were prohibited for Individual #2. Individual #176's staff was not sure if any restraints were prohibited and said the information was somewhere in her record.

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.

			Individuals:								
#	Indicator	Overall Score	147	313	35	2	176				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 9/9	1/1	2/2	2/2	2/2	2/2				
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A				

Comments:

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

			Individuals:								
#	Indicator	Overall Score	147	313	35	2	176				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	44% 4/9	0/1	0/2	2/2	1/2	1/2				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	100% 2/2	N/A	N/A	1/1	1/1	N/A				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	100% 2/2	N/A	N/A	1/1	1/1	N/A				

Comments: a. The crisis intervention restraints reviewed included those for: Individual #147 on 10/8/15 at 2:55 p.m. (chemical); Individual #313 on 9/27/15 at 8:44 p.m., and on 10/27/15 at 6:12 p.m.; Individual #35 on 8/28/15 at 4:10 p.m., and 10/29/15 at 7:36 p.m.; Individual #2 on 9/5/15 at 7:39 p.m., and 10/10/15 at 4:40 p.m.; and Individual #176 on 9/8/15 at 9:35 p.m., and 9/18/15 at 5:05 p.m. (chemical).

- Nursing staff initiated monitoring within 30 minutes except for Individual #2 on 9 10/10/15 at 4:40 p.m.
- Documentation for the following restraints were missing pulse oximetry and/or respirations Individual #313 on 9/27/15 at 8:44 p.m., and on 10/27/15 at 6:12 p.m.; Individual #2 on 9 10/10/15 at 4:40 p.m.; and Individual #176 on 9/8/15 at 9:35 p.m.
- Documentation of medication effects and/or mental status descriptions were not sufficient for Individual #147 on 10/8/15 at

2:55 p.m. (chemical); Individual #313 on 9/27/15 at 8:44 p.m.; and Individual #176 on 9/8/15 at 9:35 p.m. (i.e., late entry).

b. It was positive to see that restraint-related injuries or other negative health effects were documented, and nursing staff took action to meet the needs of the individual.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
			Individuals:								
#	Indicator	Overall Score	147	313	35	2	176				
15	Restraint was documented in compliance with Appendix A.	89% 8/9	0/1	2/2	2/2	2/2	2/2				

Comments:
15. Individual #147's restraint documentation was blank for staff who applied the restraint. For a chemical restraint, there should be an entry for the nurse who administered the chemical.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
			Individuals:								
#	Indicator	Overall Score	147	313	35	2	176				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 9/9	1/1	2/2	2/2	2/2	2/2				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	40% 2/5	0/1	N/A	1/2	1/2	N/A				

Comments:
17. This indicator applied to five of the restraints. Two showed good implementation of the recommendations. The others are described below.

- Individual #147, his 10/9/15 ISPA included two recommendations (change his room, personal TV time). There was no documentation of implementation, though his medications and level of supervision were changed.
- Individual #35, his 8/28/15 restraint included four recommendations, one of which was to update his PBSP. This happened, but not until November 2015.
- Individual #2, his 9/5/15 restraint included recommendation for collection of data on engagement, blood sugar levels, sleep, and medication schedule. There was no indication of implementation of these activities.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	7	2	176	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	0% 0/10	0/1	0/1	0/2	0/1	0/1	0/1	0/2	0/1	

Comments:

The Monitoring Team reviewed 10 investigations that occurred for eight individuals. Of these 10 investigations, six were DFPS investigations of abuse-neglect allegations (none confirmed, three unconfirmed, one inconclusive, one clinical referred back to the facility). The other four were for facility investigations of serious injury, unauthorized departure, contact with law enforcement, or 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 #339, DFPS 43965894, UIR 16, clinical referral for neglect allegation, 9/14/15
- Individual #147, UIR 154, serious injury, hip, 7/13/15
- Individual #313, DFPS 43762973, UIR 128, unconfirmed physical abuse allegation, 6/9/15
- Individual #313, UIR 146, sexual incident, unknown date
- Individual #35, DFPS 43895537, UIR 193, unconfirmed emotional abuse allegation, 8/12/15
- Individual #306, DFPS 43943645, UIR 2, unconfirmed neglect allegation, 9/2/15
- Individual #7, DFPS 43899219, UIR 195, inconclusive physical abuse allegation, 8/13/15
- Individual #2, DFPS 43917282, UIR 199, unconfirmed physical abuse allegation, 8/21/15
- Individual #2, UIR 203, UAD with law enforcement, unknown date
- Individual #176, UIR 151, sexual incident, unknown date

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

Criminal background checks were completed for all staff. About half of the staff, however, had not properly signed the annual duty to report forms (i.e., 1020 forms). They were either out of date or illegible; some were a number of years old. This important protection affected the rating for nine of the investigations (i.e., all but Individual #7 UIR 195). Ensuring staff know their reporting responsibilities is very important, and ensuring their 1020s are completed annually is one of the easiest ways to make this more likely. This was the first time the Monitoring Team has found widespread problems with 1020 forms across an entire facility.

Four of the investigations met the other criteria for this indicator, that is, protections were in place, except for staff annual duty to report forms (Individual #147 UIR 154, Individual #306 UIR 2, Individual #176 UIR 151, Individual #2 UIR 199).

Of the other six investigations, none showed a review or analysis of past allegations, injuries, or incidents.

- Individual #339, UIR 16, the facility provided a list of injuries, but no evidence of review or analysis, or actions taken.
- Individual #313, UIR 128, in the UIR, the facility noted past allegations, but there was no analysis of trends. ISPAs from 5/22/15 and 6/5/15 showed some proactive planning taken by the IDT, but there was no evidence of implementation or review.
- Individual #313, UIR 146, in the UIR, the facility noted past allegations, but there was no analysis of trends. ISPAs from 6/24/15 showed some proactive planning taken by the IDT, but there was no evidence of implementation or review.
- Individual #35, UIR 193, in the UIR, the facility noted past allegations, but there was no analysis of trends. The facility, in response to additional opportunities for information from the Monitoring Team said that there was no submission material available for this request.
- Individual #7, UIR 195, in the UIR, the facility noted past allegations, but there was no analysis of trends. ISPAs showed some proactive planning taken by the IDT, but there was no evidence of implementation or review.
- Individual #2, UIR 203, in the UIR, the facility noted past allegations, but there was no analysis of trends. The facility submitted documentation regarding management of restraint, but this allegation was not related a restraint issue (UIR 199 for this same individual was restraint-related).

Generic, standardized statement regarding the presence of a PBSP, for example, in the relevant history section of the UIR does not demonstrate any attempt by the incident management department or the IDT to review and analyze trends that might be related to the specific case. A simple sentence or two may be all that is needed, such as the investigator reviewed past injury history and determined behaviors that may have been involved in those injuries were unrelated to this incident. These kinds of statements need to be in the UIR.

Three of these other six investigations showed that some proactive planning had occurred to address the type of problem involved in the incident (Individual #313 UIR 128 and UIR 146, Individual #7 UIR 195), but none had evidence of implementation.

When recommendations require IDT action, the Monitoring Team looks for documentation of implementation in the file. Documentation of implementation may vary, depending on the nature of the recommendation, though typically the QIDP monthly review should include verification of implementation and monitoring for efficacy. Additional evidence might also be found in ISPAs, PNMT reports, PBSPs, and revised IHCPs. In order to confirm implementation, the incident management department at Lufkin SSLC may want to consider requesting evidence of implementation and include that evidence in the investigation file.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	7	2	176	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	80% 8/10	1/1	1/1	2/2	1/1	1/1	1/1	1/2	0/1	

Comments:

2. The Monitoring Team rated five of the investigations as being reported correctly. The others 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. Many of the incidents were reported to the after hours duty officer, but this person was, by policy, considered to be the facility director designee. 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 #2, UIR 203, the UIR showed that the incident occurred at 6:30 pm and was reported to facility director at 2:48 am.
- Individual #176, UIR 151, the UIR does not show that the facility director was ever notified

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.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	7	2	176	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 8/8	1/1	1/1	2/2	1/1	1/1	1/1	2/2	1/1	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	88% 7/8	0/1	1/1	2/2	1/1	1/1	1/1	2/2	1/1	
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 8/8	1/1	1/1	2/2	1/1	1/1	1/1	2/2	1/1	

Comments:

3. Staff were knowledgeable about individuals and about ANE and incident reporting.
4. Individual #339's ISP did not show that the standard abuse/neglect material was provided to the LAR.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	7	2	176	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	90% 9/10	0/1	1/1	2/2	1/1	1/1	1/1	2/2	1/1	
Comments: 6. Individual #339 UIR 16, this was a DFPS clinical referral regarding improper usage of the individual's enteral feeding machine. The facility initiated an immediate review by the nurse operations officer, with a detailed report by the end of the day of the date of the allegation. But, there was no indication that the nurses involved were placed on administrative leave or that any other client protection measures (such as increased supervision) were put in place. Further, there was nothing noted in the UIR regarding actions taken to address apparent deficient nursing practices, such as providing immediate retraining, providing 1:1 supervision, etc. In its response to the draft report, the state presented additional information regarding some of these activities, however, they were not referenced in the UIR, which should document the facility's follow-up to a DFPS administrative referral. The facility investigation process (articulated in the UIR) failed to include any of this detail, or a summary of the detail, either of which would have been acceptable for meeting criterion.										

Outcome 5– Staff cooperate with investigations.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	7	2	176	
7	Facility staff cooperated with the investigation.	100% 8/8	1/1	1/1	2/2	1/1	1/1	1/1	2/2	1/1	
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	7	2	176	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	60% 6/10	0/1	0/1	1/2	1/1	1/1	1/1	1/2	1/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	70% 7/10	1/1	0/1	1/2	1/1	1/1	1/1	1/2	1/1	
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	70% 7/10	1/1	0/1	1/2	1/1	1/1	1/1	1/2	1/1	

Comments:
8-10. Four investigations did not meet criteria with indicator #8. Three of the four did not meet criteria with indicators #9-10. Note that these three failed to interview all staff named as involved.

- Individual #339, UIR 16, the alleged serious allegations of enteral feeding issues were not investigated by the facility-trained investigator. The UIR conclusion was "Nursing to determine if peer review is necessary." Evidence presented in the DFPS Referral report placed a burden on the facility to conduct a thorough and complete investigation by a facility investigator. Instead, the investigation was conducted by the nurse operations officer who, presumably, was not a trained investigator and not aware of the standard data items and methodology for an investigation and a report presentation. While some of these standard requirements were present, many were not.

  When an investigation is delegated because of the clinical nature of the allegation, the IMC should ensure that the investigation includes the items required by the Settlement Agreement (i.e., these indicators) and that conclusions and recommendations are reported back to the IMC for inclusion in the UIR, either in detail or in summary form. In other words, the IMC should maintain some level of administrative oversight as the clinical investigation proceeds. The vast majority of administrative referrals are allegations of neglect that did not rise to the definition of neglect (i.e., there was no harm to the individual) and need facility investigation to ensure ongoing client protections are in place. The bottom line is that this investigation did not contain all the required investigation elements. Some degree of oversight by the IMC could have addressed this proactively.

- Individual #147, UIR 154, there was no evidence in the UIR that any of the 11 staff named as involved were interviewed. Further, the investigation did not offer a conclusion (the cause noted was other, without further explanation other than he had osteoporosis) as to what happened that resulted in the serious injury (e.g., accidental injury, staff improper implementation of a procedure).
- Individual #313, UIR 146, not all staff named as involved were interviewed, therefore, not all evidence could have been considered.
- Individual #2, UIR 203, not all staff named as involved were interviewed, therefore, not all evidence could have been considered.

Outcome 7– Investigations are conducted and reviewed as required.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	7	2	176	
11	Commenced within 24 hours of being reported.	100% 10/10	1/1	1/1	2/2	1/1	1/1	1/1	2/2	1/1	
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 10/10	1/1	1/1	2/2	1/1	1/1	1/1	2/2	1/1	
13	There was evidence that the supervisor had conducted a review of	60%	0/1	0/1	1/2	1/1	1/1	1/1	1/2	1/1	

	the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	6/10									
Comments: 13. The investigations that did not meet criteria did not identify problems in the investigation report, such as failure to interview all individuals involved, reassignment of alleged perpetrator, or conduct of the nursing operations officer review outside of the context of the facility's Review Authority. The expectation is the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.											

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	7	2	176	
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 9/9	3/3	1/1	N/A	N/A	2/2	N/A	2/3	N/A	
Comments: 15. This indicator applied to four of the individuals. The facility did not provide non-serious injury investigations as part of the document request, however, while onsite the Monitoring Team received relevant documents.											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	7	2	176	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 7/7	1/1	1/1	2/2	N/A	1/1	1/1	1/1	N/A	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	50% 1/2	0/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	
18	If the investigation recommended programmatic and other actions,	20%	0/1	0/1	1/1	N/A	0/1	N/A	0/1	N/A	

	they occurred and they occurred timely.	1/5									

Comments:
17. This indicator applied to two of the investigations, and criterion was met for one. For Individual #339 UIR 16, the investigation conducted by the NOO reported on many actions being implemented, however, while onsite, the Monitoring Team was unable to validate that the planned actions had occurred and no additional information was available from the incident management department.

18. This indicator applied to five of the investigations and criterion was met for one. For Individual #339 UIR 16 and Individual #147 UIR 154, no documentation was provided. For Individual #306 UIR 2, the three recommendations were combined into one non-specific "request assistance from State office clinical coordinator," but no evidence showed that this, or any other, follow-up occurred. For Individual #2 UIR 203, documentation showed only one of four UIR recommendations had occurred (retraining of staff).

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									

Comments:
19-23. Data were being collected and subjected to some analysis with narrative explanations, however, there was insufficient usage of those data to complete the activities of indicators 21-23.

Psychiatry

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.)												
			Individuals:									
#	Indicator	Overall Score	147	176								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	50% 1/2	1/1	0/1								
48	Multiple medications were not used during chemical restraint.	100% 2/2	1/1	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	50% 1/2	1/1	0/1								
Comments: 47-49. The review of the restraint regarding Individual #147 dated 10/08/15 revealed appropriate documentation. The restraint incident review regarding Individual #176 on 09/18/15 revealed a lack of documentation regarding the psychiatric post restraint review and clinical follow-up.												

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. The State did not have a policy for determining whether or not individuals met criteria for the use of TIVA. In its document request, the Monitoring Team specifically asked for the Facility's dental policies. Instead of submitting the requested policies, the Facility submitted a statement that read: "Policies have not been updated since the last Monitor's visit." In the future, the Facility should submit all documents the Monitoring Team requests. In the last report, the Monitoring Team concluded: "The Facility included guidelines for TIVA in the dental services policy. The Facility required Pharmacy, Psychiatry, and Medical staff to collaborate and review the use of TIVA and/or sedation, and summarize those										

findings in a consultation report. However, there was no specific requirement for the PCP to complete a through pre-operative assessment to determine if the individual was actually a candidate for on-campus TIVA." Given that the Facility submitted no new information, this finding remains applicable for this review. The standard of care requires that individuals that meet certain criteria (e.g., age, medical problems, etc.) undergo a perioperative evaluation by the primary care practitioner. Although records indicated that Individual #227's PCP conducted a perioperative evaluation, without a policy setting forth criteria, it could not be determined whether or not proper procedures were followed.

In addition, the operative note provided no detail on the procedures performed other than "scale and probe; applied fluoride; and #18 composite." Information such as the local anesthetics, and operative techniques were not documented. The dentist also provided no documentation as to the condition of the individual following the procedure.

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

Outcome 9 – Individuals receive medical pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	100% 4/4	N/A	N/A	3/3	1/1	N/A	N/A	N/A	N/A	N/A

Comments: It was positive that for the two individuals reviewed for whom medical pre-treatment sedation was used proper procedures were followed.

Of note, for Individuals #494, the pharmacy orders included orders for versed 10 milligrams (mg) by mouth (PO) written on 11/5/15 and 10/27/15. The medication was to be given prior to studies being done off campus. Oral versed has a very short half-life. If given at the Facility prior to transport for a diagnostic study, it might have little effectiveness for procedural sedation. In addition, this medication is usually administered in settings where the individual is being monitored. It was not clear how this could be accomplished in the manner in which was being prescribed. The last IPN submitted was dated 10/31/15, and no monitoring documentation was submitted related to these two orders. As a result, the Monitoring Team could not determine if the ordered medication was administered, and if so, if proper procedures were followed. However, it was concerning that these orders had been written, especially without specific monitoring parameters.

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
			Individuals:								
#	Indicator	Overall Score									
1	If the individual received PTS in the past year for routine medical or	N/A									

	dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year										
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	N/A									
3	Action plans were implemented.	N/A									
4	If implemented, progress was monitored.	N/A									
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A									
Comments: 1-5. None of the individuals reviewed were reported to have received PTS for routine medical or dental care for the time period reviewed by the Monitoring Team.											

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
			Individuals:								
#	Indicator	Overall Score	447	588	560	492	137	497	413		
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% 7/7	1/1	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.	43% 3/7	1/1	0/1	1/1	0/1	0/1	1/1	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.	43% 3/7	1/1	0/1	1/1	0/1	0/1	1/1	0/1		
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	43% 3/7	1/1	0/1	1/1	0/1	0/1	1/1	0/1		
e.	Recommendations are followed through to closure.	29% 2/7	1/1	1/1	0/1	0/1	0/1	0/1	0/1		
Comments: a. Since the last review, 11 individuals died. The Monitoring Team reviewed seven of these deaths. Three individuals died shortly before the Monitoring Team's onsite review, so complete mortality review and follow-up documentation was not yet available.											

Causes of death were listed as:

- For Individual #161, at age 83 of myocardial infarction;
- For Individual #447, at age 48 of respiratory failure, chronic aspiration, and chronic obstructive pulmonary disease (COPD);
- Individual #588, at age 29 of pneumonia;
- Individual #560, at age 60 of septic shock, respiratory failure, bilateral pneumonia, and urinary tract infection (UTI);
- Individual #492, at age 50 of severe coronary artery disease, left ventricular hypertrophy, fatal arrhythmia, and severe heart disease;
- Individual #137, at age 47 of respiratory failure, bilateral pneumonia, and anemia;
- Individual #497, at age 63 of sepsis, metabolic acidosis, bilateral pneumonia, and acute kidney failure due to sepsis;
- Individual #413, at age 58 of aspiration pneumonia, and aspiration of gastric contents; and
- Individual #470, at age 64 of septic shock, respiratory failure, bilateral pneumonia, and UTI.

Causes of death were pending for Individual #520, who died at age 51, and Individual #444, who died at age 81.

b. through d. The clinical and administrative death reviews included a number of valuable recommendations. As discussed in further detail below, most of them were not written in a manner that ensured Facility practice and/or outcomes for individuals actually changed. In other words, new processes were recommended, but outcomes of these new processes were not measured to ensure the underlying issues were addressed. The following provides examples of some of the other concerns related to mortality reviews:

- Overall, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the clinical death review or that all nursing recommendations, or nursing practice concerns were consistently acknowledged in the administrative death review.
- For Individual #588 and Individual #137, the Clinical Death Summary identified omissions on the part of the IDT in re-assessing risk based on the individuals' vomiting episodes, but no recommendations were found to address this concern.
- For Individual #492, the Clinical Death Summary identified omission of a Change of Status IHCP or IRRF, post-hospitalization for his acute respiratory failure and his CPAP mask, but no corresponding recommendation was found, particularly related to supervision issues.
- For Individual #413, issues related to timely receipt of medications was addressed through a retrospective review versus "live audits." Given the critical nature of this issue, a more proactive approach was warranted.

e. For a number of recommendations, data were not submitted to support that they were completed, and/or Facility tracking showed that completion of the recommendations was "late." In addition, the recommendations generally were not written in a way that ensured that Facility practice had improved. For example, a recommendation that read: "BiPAP/CPAP compliance should be placed on trigger sheet to track if there are issues going on with individuals not wearing the machines as prescribed. Nurses need to be in-serviced on the updated form" was considered completed when a revised trigger sheet was developed and in-service training was complete. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required closure to include monitoring to determine whether or not individuals were wearing their prescribed devices and/or that IDTs were addressing ways to improve compliance with the use of BiPAP/CPAP machines.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	ADRs are reported immediately.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 1/1			1/1						
c.	Clinical follow-up action is taken, as necessary, with the individual.	0% 0/1			0/1						
d.	Reportable ADRs are sent to MedWatch.	100% 1/1			1/1						
Comments: a. through d. Individual #494 had a rash, which was considered a reaction to Lamictal. Facility staff reported it to MedWatch. The PCP documented improvement of the rash, but did not document resolution of the rash. A reaction deemed worthy of reporting it to the Federal Drug Administration (FDA) should have adequate documentation of follow-up by the PCP through to resolution.											

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.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	0% 0/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2
Comments: a. and b. The Facility submitted what staff considered as two DUEs. However, neither was a DUE. A drug utilization evaluation is a performance improvement method that focuses on evaluating and improving medication-use processes with the goal of optimal patient outcomes. More specifically, the Healthcare Guidelines define a DUE as: "…an ongoing, systematic, criteria-based method of obtaining information about medication use. This method ensures the appropriate use of drugs by identifying potential problems related to drug utilization and by providing a means to correct the problems… The goal of DUE is to assure the appropriateness, safety and effectiveness of medication use… The evaluation should also address indications, absolute and relative contraindications, screening thresholds, and adverse effects, as described in the state's drug formulary…" The Facility submitted a PowerPoint on the use of Keppra (i.e., Levetiracetam-Induced Behavioral Side Effects). There was no data for analysis, and therefore, no specific conclusions about the use of the drug at the Facility.		

	The 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce ASCVD [atherosclerotic cardiovascular disease] in Adults was a presentation on the management of lipid abnormalities. It was not a drug utilization evaluation. There was minimal information presented on the management of hyperlipidemia at the Facilty. There was no data for analysis. Therefore, the PowerPoint did not provide any conclusions or recommendations.

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.

ISPs

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

			Individuals:								
#	Indicator	Overall Score	147	313	306	2	227	532			
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.	0/6 0%	1/6	1/6	0/4	1/6	0/6	0/6			
2	The personal goals are measurable.	0/6 0%	0/6	1/6	0/6	1/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0/6 0%	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:

The Monitoring Team reviewed six individuals to monitor the ISP process at the facility (Individual #306, Individual #147, Individual #313, Individual #2, Individual #227, Individual #532). The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Lufkin SSLC campus.

The Monitoring Team had the opportunity to review three of the newest ISPs. These were for Individual #532 and for two other individuals not in the group chosen for full review. Individual #532's ISP was newly developed, but was not included in this review because it had not yet been implemented. The Monitoring Team was pleased to see that these newer ISPs showed significant improvement in IDT's developing person centered plans with individualized measurable outcomes. The new ISP template guided IDTs to set individualized goals, explore new opportunities for skill building, and address barriers to individuals achieving their goals. This was very positive to see. The Monitoring Team looks forward to reviewing implementation of the newer ISPs during the next round of visits.

1. Most outcomes for individuals remained very broadly stated and general in nature. They were not individualized. Goals did not identify preferences for specific day activity or living options and, in many instances, did not offer an opportunity to learn new skills. For example, four individuals had living option outcomes to be exposed to community living options by visiting in the community. The other two had living option goals to remain at LSSLC. All six had leisure/recreation outcomes that stated "will participate in leisure activities of his/her choice."

2. Goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting goals had been achieved. Examples of personal outcomes that were not measurable included Individual #532's greater independence goal to "display skills which will aid in her independence" and Individual #147's outcome "will display self-help skills through training."

Personal goals should be aspirational statements of outcomes. Some personal goals may be readily achievable within the coming year, while some many will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

3. Review of data implementation sheets and QIDP monthly reviews indicated that data were collected for most ISP action plans. Monthly reviews of services and supports found various gaps in implementation and data collection for all of the individuals. In some cases, it was noted that goals were never fully implemented during the ISP year. As noted, personal outcomes and many action plans were not measurable, therefore, there was no basis for assessing whether reliable and valid data was available. To reiterate, however, recent improvements should be evident at the time of the next monitoring review.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
			Individuals:								
#	Indicator	Overall Score	147	313	306	2	227	532			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	1/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most	33%	0/1	1/1	0/1	0/1	1/1	0/1			

	integrated setting consistent with the individual's preferences and support needs.	2/6									
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	1/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	2/6	2/6	2/6	1/6	3/6	1/6			

Comments: As Lufkin SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators.

8. Personal goals were not well defined in the ISPs, as indicated above.

9. Preferences and opportunities for choice were not well integrated in the individuals' ISPs. Individuals had limited opportunities to learn new skills based on identified preferences. In most cases, there was no discussion regarding specific preferences for day programming. ISPs defined day programming by where the individual would receive services (e.g., school, 560 building), however, preferences for specific activities and skill building opportunities were not defined. ISPs did not include discussion regarding opportunities for choice throughout the day.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the individuals. None of the individuals had action plans related to informed decision-making.

11. Without well-defined personal goals, it was difficult to determine if action plans would support the individuals to be more independent. Action plans for five of six individuals did little to support their enhanced independence.

- For Individual #147, the IDT identified that purchasing items should be an action plan to increase his independence. A SAP was never developed for training.
- For Individual #313, the IDT recommended a SAP for bathing to increase his independence. It was never developed.
- Individual #2's SAPs (brush teeth, shower, wear glasses, attend work) appeared to address compliance issues rather than teaching him new skills to gain independence.
- Individual #532's toothbrushing SAP also appeared to be a compliance issue rather than an opportunity to build skills that would make her more independent.
- Individual #227 had a SAP to identify coins that was not functional for her.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans. All individuals had an IHCP to address risks, however, not all risks were identified and supports to address risk were not typically integrated into other parts of the ISP. See additional comments related to At-Risk outcomes.

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. Examples included:

- Individual #306's IDT had developed multiple supports to address his risk for falls. There appeared to be little integration, however, between neurology, psychiatry, and habilitation therapy in developing and monitoring his supports.
- Individual #147, Individual #2, and Individual #227's team members suggested that changes in behavior could possibly be related to medical issues. It was not evident that their teams had clearly explored the relationship between medical issues and behavioral issues.
- Recommendations from Individual #532's communication assessment were not implemented or integrated into supports strategies.

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

15. With the exception of the two school-aged individuals, IDTs had not considered opportunities for day programming in the most integrated setting, consistent with the individual's preferences and support needs.

- Individual #532 was 33 years old and had no documented experience in a work environment. Her last vocational assessment was completed in 2011.
- Individual #306's IDT recommended a vocational assessment. It was never completed.
- Individual #2's IDT reported that he was working in the community two days per week. His ISP did not reflect community employment and the team failed to develop supports to ensure that it was a successful experience for him. At the time of the monitoring visit, he was at risk for losing his job due to the lack of necessary supports.
- Individual #147 and Individual #532 were assigned to day programs with minimal description in the ISP of how day programs related to their preferences or opportunity to build new skills.

16. Within the ISP, opportunities for functional engagement with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs were only evident for the two individuals attending school. This is another area that is likely to improve with the newer ISPs, in part, because there is a section devoted to the IDT's discussion of the individual's daily schedule, activities, and engagement.

17. Overall, individuals were making little progress towards outcomes and barriers were not consistently identified and addressed in the ISP, as noted in other sections of this report, particularly barriers related to health.

18. For the most part, ISPs did not include collection of enough, or the right types of, data to make decisions regarding the efficacy of supports. SAPs often did not describe the behavioral objective. IHCP goals/objectives and interventions were often not measurable. IHCPs and many other action plans were written as staff actions without specific criteria for measuring progress. For example,

- Individual #313 had an outcome to be exposed to the community with action plans to attend a provider fair and participate in community excursions based on IDT decision. It was not clear what data would need to be gathered or what would constitute progress or completion of this outcome.
- Individual #2 had an action plan to address his living option outcome to shop in stores, such as Academy and Game X-change.

Again, it was not clear what data should be recorded and what would constitute progress.

- Individual #147 had an action plan to shop for his personal items bi-annually. It was not clear what staff should collect data on or what he would need to complete independently. It was unlikely that he would become more independent at shopping if the action plan was only implemented twice a year.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
			Individuals:								
#	Indicator	Overall Score	147	313	306	2	227	532			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	50% 3/6	1/1	0/1	1/1	0/1	1/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
23	The determination was based on a thorough examination of living options.	50% 3/6	0/1	1/1	0/1	0/1	1/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	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.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	0% 0/4	0/1	0/1	0/1	N/A	N/A	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Comments:											

19. Two of six ISPs included a description of the individual's preference and how that was determined. Individual #2 and Individual #227 had both recently moved from the community, so were more aware of their options. For the remainder, preferences were largely unknown.

20. There were no annual ISP meetings for any of the individuals chosen for review. The Monitoring Team, instead, observed the annual ISP for another individual, Individual #587. The local authority attendees presented about her discussions with the individual. Further, the individual stated very clearly that she didn't want to live in a group home, but instead wanted to live in an apartment someday. Moreover, she said that she wanted to continue to live at Lufkin SSLC for now. This observed ISP was also used for the scoring of indicators 25 and 27.

21. Three of six ISPs included a statement regarding the overall decision of the entire IDT, exclusive of the individual and LAR. The opinions of key staff members were not documented for Individual #313 (psychiatrist), Individual #2 (psychiatrist), and Individual #532 (nurse).

22. Five of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. For Individual #227, the summary statements were contradictory.

23. Three individuals (Individual #313, Individual #227, Individual #532) had a thorough examination of living options based upon their preferences, needs, and strengths.

24. Five of six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. The summary statement in Individual #532's ISP indicated that her LAR was against community placement. LAR preference was not listed as a barrier to placement.

26. None of the ISPs included measurable action plans to address barriers to community placement. There were no individualized action plans to address identified barriers to LAR choice. Action plans to address individual awareness were not consistently individualized or measurable. For example, the majority of action plans for individual awareness were to participate in community leisure activities and/or participate in a provider fair, with no detail as to the learning needs of the individual, no methodology addressing increasing awareness and preference development, and no criteria for how these outcomes would be measured.

27. Although obstacles to referral were identified, a reasonable set of plans (i.e., personal goal and action plans) were not developed.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
			Individuals:								
#	Indicator	Overall Score	147	313	306	2	227	532			
30	The ISP was revised at least annually.	100% 5/5	1/1	1/1	1/1	N/A	1/1	1/1			

31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	50% 3/6	1/1	0/1	1/1	0/1	1/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	50% 3/6	1/1	0/1	1/1	0/1	0/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			

Comments:

30. ISPs were developed on a timely basis.

31. Individual #2 was the only individual admitted to the facility in the past year. His ISP was developed within 30 days of admission.

32. Three of six ISPs were implemented within 30 days of development.
    - Individual #313's QIDP monthly reviews indicated that data were not available for some action plans from May 2015 through August 2015. There was no documentation to show that a SAP was ever developed for bathing or that a recommended exercise program was developed.
    - Individual #2's QIDP monthly reviews indicated that action plans for applying deodorant and wearing his glasses were not implemented until September 2015 (his ISP meeting was in July 2016). His action plan for home visits with his mother was not implemented and barriers were not documented.
    - Individual #532's speech therapy was not implemented until months after development of her ISP and then was discontinued without IDT discussion.

33. Individual #313, Individual #2, and Individual #227 did not attend their IDT meetings.

34. Four individuals did not have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples included:
    - Day training and vocational staff did not attend Individual #306's ISP annual meeting and his vocational assessment was not submitted prior to the meeting, despite a team recommendation for an updated assessment.
    - Individual #313's LAR and ISD school representative did not attend his meeting.
    - Day program staff did not attend Individual #147's meeting.
    - The speech therapist did not attend Individual #532's meeting, despite noted gaps in services and inconsistent implementation of recommendations during the previous year.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
			Individuals:								
#	Indicator	Overall Score	147	313	306	2	227	532			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	50% 3/6	1/1	1/1	0/1	1/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP Preparation meeting, for six of six individuals.

36. All needed assessments were not submitted prior to the annual IDT meeting for three of six individuals. Individual #306's vocational assessment was not completed prior to his annual meeting. An update was requested the previous ISP year and had still not been completed prior to his current ISP development. Additionally, he had a speech screen on 2/26/15 that recommended a comprehensive speech assessment within 30 days. It was not completed until 12/7/15. Individual #227 did not have a comprehensive speech evaluation prior to her ISP meeting and Individual #532's last vocational assessment was completed in 2011.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
			Individuals:								
#	Indicator	Overall Score	147	313	306	2	227	532			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

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

- Individual #306's data sheets and QIDP monthly review indicated that the toothbrush recommended by the IDT to address his dental refusals was missing for several months, therefore, his toothbrushing SAP could not be implemented as written. There was no documented follow-up by the IDT to replace his toothbrush.
- Individual #147's physical aggression had greatly increased in the last several months with no revision to his behavioral

supports.

- Significant gaps in OT services for Individual #227 were not addressed. Her speech services were discontinued without reviewing progress and making recommendations to ensure that she received communication supports needed.
- Individual #532's QIDP monthly reviews indicated an increase in peer-to-peer aggression and refusals. There was no documentation of team discussion or a revision of her supports to address either.

38. QIDPs were completing monthly reviews consistently. This was a very positive improvement since the last monitoring visit. It was not evident, however, that this review resulted in action taken when ISPs were not implemented or not effective.

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

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	The individual's risk rating is accurate.	67% 12/18	0/2	0/2	1/2	1/2	2/2	2/2	2/2	2/2	2/2
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.	72% 13/18	2/2	0/2	1/2	2/2	1/2	2/2	1/2	2/2	2/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #306 – skin integrity, and constipation/bowel obstruction; Individual #147 – gastrointestinal problems, and constipation/bowel obstruction; Individual #494 – gastrointestinal problems, and constipation/bowel obstruction; Individual #227 – constipation/bowel obstruction, and UTIs; Individual #521 – infections, and skin integrity; Individual #588 – gastrointestinal problems, and infections; Individual #255 – hypothermia, and infections; Individual #481 – constipation/bowel obstruction, and seizures; and Individual #532 – seizures, and constipation/bowel obstruction).

a. The IDTs that did not effectively use supporting clinical data when determining a risk level were those for Individual #306 – skin integrity, and constipation/bowel obstruction; Individual #147 – gastrointestinal problems, and constipation/bowel obstruction; Individual #494 –constipation/bowel obstruction; and Individual #227 – UTIs. Individual #147's IDT did not provide justification for not adhering to the guidelines with regard to constipation/bowel obstruction.

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. Some examples included:

- Individual #494's most recent ISP was dated 10/29/15. On 9/10/15, the individual was sent to the ED for the absence of bowel sounds, and the documentation from the ED record noted: "constipation for a month." The individual had previously required six enemas, the last one per the Nursing Assessment occurred on 9/23/15, and Individual #494 had an acute care plan to address the "acute constipation." After the ED visit, the IDT should have met to discuss and consider elevating his risk level from low to medium or high, rather than waiting until the annual ISP meeting to increase the risk from low to medium.

- In August, September, and October 2015, Individual #255 had episodes of hypothermia. His risk level per the 2014 ISP was low for hypothermia. The IDT should have met to consider raising the risk to a higher level, rather than awaiting the annual ISP. The provided ISPAs noted the hypothermia, but there was no re-evaluation of the risk level.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

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

For example, for Individual #306, data were being collected for physical aggression, protest behavior, and disruptive behavior. These, however, were unrelated to his specific diagnosis of Bipolar II and it was noted that, historically, his psychiatric condition was evidenced by episodes of mild rapid persistent speech, agitation, and a history of severe depression. To meet criterion with this outcome, these symptoms should be operationalized in measurable terms and monitored to allow for data driven decisions regarding his medications and psychiatric treatment.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
12	The individual has a CPE.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									
13	CPE is formatted as per Appendix B	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 4/4	N/A	N/A	1/1	1/1	N/A	N/A	1/1	1/1	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
12-13. All had a CPE, though two (Individual #339, Individual #313) were not formatted as required by the Settlement Agreement. Individual #339's evaluation was completed in 2011 and Individual #313's was completed in 2014. While all of the required information was present, the formatting was different.

14. The Monitoring Team looks for 14 components in the CPE. Evaluations regarding Individual #339, Individual #147, Individual #306, and Individual #88 had all of the required components. The evaluations for Individual #313, Individual #35, and Individual #7 were completed on the day of admission were missing one item: lab values. The Monitoring Team, however, rated this as meeting criterion because of the timeliness of the CPE and also because lab values were reviewed regularly at part of their subsequent quarterly and annual reviews. Individual #2's CPE was missing a medical history, physical examination, and lab values; Individual #176's, written in 2012, was missing an adequate bio-psycho-social formulation.

16. All met criterion, except Individual #147 because schizoaffective disorder, impulse control disorder, and attention deficit hyperactive disorder diagnoses in the annual medication assessment were not included in the psychiatric documentation.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
17	Status and treatment document was updated within past 12 months.	100% 6/6	1/1	1/1	1/1	N/A	1/1	1/1	N/A	N/A	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	67% 4/6	1/1	1/1	1/1	N/A	0/1	0/1	N/A	N/A	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	days prior to the ISP and was no older than three months.	9/9									
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18. The Monitoring Team scores 16 aspects of the annual evaluation document. Information regarding non-pharmacological treatment was missing from Individual #88's evaluation, and the risk-benefit discussion regarding medication was missing from Individual #306's evaluation. Otherwise, in general, the annual evaluations were of good quality.

19-20. Documentation was submitted to the ISP team in a timely manner and the psychiatrist or member of the psychiatric team attended all annual ISP meetings.

21. There was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits. The Monitoring Team looks for the above noted aspects of psychiatry participation. One individual, Individual #339, met criterion.

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

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. One individual, Individual #147, had a PSP. As noted in the scoring of psychology/behavioral indicator #1, he had displayed behavior problems for a number of months and a PBSP was now more appropriate rather than solely a PSP.

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

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

29	The written information provided to individual and to the guardian was adequate and understandable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
30	A risk versus benefit discussion is in the consent documentation.	67% 6/9	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	22% 2/9	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
28. Consents met criterion for each individual for this indicator.

29. There was limited information regarding side effects included in the consent form itself. Previously, there was documentation that a handout regarding medication side effects had been provided to the consenter. This was not noted on the new consent form.

30-31. There was a brief review of risks versus benefits in the consent documentation, with more detailed information included in the annual assessment or quarterly psychiatric reviews. Similar issues were noted with alternate and non-pharmacological interventions that were considered. There was a need for improvement with regard to the identification and documentation of alternate 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.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
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.	92% 12/13	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 8/8	1/1		1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8	1/1		1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	100%	1/1		1/1	1/1	1/1	1/1	1/1	1/1	1/1

		8/8									
5	Reliable and valid data are available that report/summarize the individual's status and progress.	62% 5/8	0/1		1/1	1/1	1/1	1/1	0/1	0/1	1/1

Comments:
1. Of the 15 individuals reviewed by both Monitoring Teams, 13 required a PBSP (nine of the individuals reviewed by the behavioral health Monitoring Team and four individuals reviewed by the physical health Monitoring Team). Twelve of those individuals had PBSPs. The exception was Individual #147 (reviewed by the behavioral health Monitoring Team) who did not have a PBSP at the time of the onsite review, but was engaging in dangerous behaviors for the last several months and, therefore, was judged to require a PBSP.

2-3. All individuals with a PBSP had measurable behavioral objectives.

4. All of the PBSPs had behaviors targeted for increase and decrease that were based upon the individual's assessments.

5. Interobserver agreement (IOA) and data collection timeliness assessments were conducted in the last six months, and were above 80% for Individual #313, Individual #35, Individual #306, Individual #88, and Individual #176. Individual #339 had acceptable IOA and data collection timeliness data, however, his October 2015 progress note indicated that replacement behaviors were not consistently recorded, therefore, his data were scored as unreliable. Individual #7's last data collection timeliness measure indicated that his PBSP data were not recorded in a timely manner, and Individual #2 had no IOA and, further, his September 2015 progress note indicated that his aggression was underreported.

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

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
10	The individual has a current, and complete annual behavioral health update.	100% 8/8	1/1	1/1	1/1		1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	71% 5/7	0/1		1/1		1/1	0/1	1/1	1/1	1/1
12	The functional assessment is complete.	86% 6/7	1/1		1/1		1/1	1/1	0/1	1/1	1/1

Comments:
Criteria for indicators 1-9 were met for Individual #35. Therefore, the remainder of the indicators in psychology/behavioral health were not rated.

10. All individuals had annual behavioral health assessments that were revised within the last 12 months.

11. All seven functional assessments were current, however, Individual #88's direct assessment and Individual #339's indirect assessment were more than a year old, with no rationale for why they were not conducted in the last 12 months.

12. Overall the functional assessments contained all of the necessary components. Individual #7's functional assessment, however, was rated incomplete because the direct assessment did not include any target behaviors or a rationale why target behaviors were not included. The Monitoring Team found Individual #306's functional assessment to be particularly good.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 7/7	1/1		1/1		1/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	100% 7/7	1/1		1/1		1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	57% 4/7	0/1		1/1		1/1	0/1	1/1	0/1	1/1
Comments: 15. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Although only four PBSPs (Individual #313, Individual #306, Individual #7, Individual #176) were rated as having all 13 components, all seven PBSPs reviewed contained the majority of these components. Individual #339's PBSP was rated as incomplete because the replacement behavior was not functional, Individual #88 and Individual #2's PBSPs were rated as incomplete because the reinforcement of the replacement behavior was not clearly stated in the PBSP.											

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A
Comments: 24-25. At the time of the onsite review, no individuals at Lufkin SSLC received counseling.											

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely quarterly reviews for the three quarters in which an annual review has not been completed.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
d.	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
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
f.	Individual receives quality quarterly medical reviews.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: d. Problems varied across medical assessments. However, in all of the medical assessments reviewed, one to three components were missing or incomplete. As applicable to the individuals reviewed, all annual medical assessments included social/smoking histories, past medical histories, interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, described complete physical exams with vital signs, included pertinent laboratory information, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include pre-natal histories, family history, childhood illnesses, and plans of care for each active medical problem, when appropriate.

e. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed.

f. It was also positive that quarterly medical reviews included the content the Quarterly Medical Review template required.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	31% 5/16	0/2	0/2	1/2	2/2	N/A	0/2	1/2	1/2	0/2
Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #306 – seizures, and constipation/bowel obstruction; Individual #147 – osteoporosis, and constipation/bowel obstruction; Individual #494 – seizures, and osteoporosis; Individual #227 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #521 – seizures, and respiratory compromise; Individual #588 – gastrointestinal problems, and aspiration; Individual #255 – respiratory compromise, and osteoporosis; Individual #481 – seizures, and hypertension; and Individual #532 – osteoporosis, and other: hypothyroidism). The ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #494 – osteoporosis; Individual #227 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #255 – osteoporosis; and Individual #481 – seizures.										

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	Individual receives timely dental examination and summary:										

	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. It was positive that with one exception for the individuals reviewed, dental examinations were completed within 365 of the previous one, but no earlier than 90 days, and dental summaries were completed no later than 10 working days prior to the ISP meeting.

b. Problems with the dental exams varied. On a positive note, all dental exams reviewed included a description of the individual's cooperation, a description of sedation use, an oral hygiene rating completed prior to treatment, an oral cancer screening, a description of periodontal condition, an odontogram, caries risk, periodontal risk, and specific treatment provided. However, staff in the Dental Department should focus on ensuring exams include information regarding last x-ray(s) and type of x-ray, including the date; include periodontal charting; include the number of teeth present/missing; state the recall frequency; and provide a treatment plan. Overall the treatment plans in the annual dental exams were limited. Treatment and recall usually stated "as per schedule." The treatment plan should be specific and indicate the proposed treatment based on the identified needs. The specific recall frequency should also be noted.

c. All of the dental summaries were missing one or more of the required elements. The following elements were included in all of the dental summaries reviewed:

- The number of teeth present/missing;
- Provision of oral hygiene instructions to staff and the individual;
- Recommendations for the risk level for the IRRF; and
- Dental care recommendations.

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

- Recommendations related to the need for desensitization or other plan. The annual dental summaries continued to have the same generic statement related to the need for desensitization: "desensitization is carried out by BHS [Behavioral Health Services]. They have access to utilize the Dental Clinic and Dental Desensitization Room as needed." In addition, even when refusals or limited cooperation was noted, the annual dental summaries did not include recommendations to increase individuals' cooperation;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- A description of the treatment provided; and
- Treatment plan, including the recall frequency.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	31% 4/13	N/A	0/2	0/2	1/2	0/1	0/1	0/2	1/1	2/2

Comments: b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #306 – skin integrity, and constipation/bowel obstruction; Individual #147 – gastrointestinal problems, and constipation/bowel obstruction; Individual #494 – gastrointestinal problems, and constipation/bowel obstruction; Individual #227 – constipation/bowel obstruction, and UTIs; Individual #521 – infections, and skin integrity; Individual #588 – gastrointestinal problems, and infections; Individual #255 – hypothermia, and infections; Individual #481 – constipation/bowel obstruction, and seizures; and Individual #532 – seizures, and constipation/bowel obstruction).

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

c. Nursing assessments often were not completed in accordance with nursing protocols or current standards of practice for individuals' changes of status. The risk areas for which changes of status occurred, and nursing assessments were completed were for: Individual #227 – constipation/bowel obstruction; Individual #481 – seizures; and Individual #532 – seizures, and constipation/bowel obstruction.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	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).	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	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).	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2	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. Problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures (i.e., the exception was the IHCP for infections or Individual #255); a lack of 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, with the exception being the IHCP for Individual #481 for seizures); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored (i.e., the exceptions being the IHCPs for seizures, and constipation/bowel obstruction for Individual #481); and/or a lack of identification of the frequency for monitoring of the individuals' health risks.

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.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	0% 0/6	0/1	0/1	0/1	N/A	N/A	0/1	0/1	0/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	17% 1/6	0/1	0/1	0/1			0/1	1/1	0/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	17% 1/6	0/1	0/1	0/1			0/1	1/1	0/1	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	17% 1/6	0/1	0/1	0/1			1/1	0/1	0/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	0% 0/2	N/A	0/1	N/A			N/A	0/1	N/A	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	17% 1/6	0/1	0/1	0/1			1/1	0/1	0/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/2	N/A	0/1	N/A			N/A	N/A	0/1	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/6	0/1	0/1	0/1			0/1	0/1	0/1	
Comments: a. through d., and f. For the six individuals that should have been referred to the PNMT: • According to the most current OT/PT assessment submitted for Individual #306, dated 3/12/14, he had experienced 33 falls. This represented an average of 2.75 falls per month, ranging from one to six (six occurring in June and November 2013).											

According to his most recent IRRF, dated 3/31/15, he had experienced 23 falls in the previous year, with non-serious injuries reported. The IRRF indicated that most of these falls were related to seizures and an unsteady gait. From April 2014 to April 2015, he experienced 38 falls with four in the 30 days prior to the PNMT referral. The IDT and/or PNMT provided no justification as to why a referral to the PNMT had not occurred before 4/16/15.

There was evidence that a limited PNMT review was conducted within five days of referral, but it was not well documented. The PNMT PT attended an ISPA meeting the IDT held to address a recent fall with injury that resulted in the referral. The PNMT did not know whether an evaluation was indicated and planned to research his fall history. This was done, but not within five days. No comprehensive assessment was ever completed, although one was indicated.

- The IDT for Individual #147 did not refer him to the PNMT for: 1) the fracture of his right hip in July 2015, or 2) frequent emesis, which increased his risk for aspiration. At a minimum, the PNMT should have conducted reviews of these events. Without a review, justification was not present to show whether or not a PNMT Comprehensive Assessment was needed.
- Individual #494's IDT referred him to the PNMT, but the referral was not timely. More specifically, the IDT documented a referral on 8/19/15, but the frequency of falls met criteria in at least July, based on available data. A PNMT note, dated 8/28/15, included a chart that recorded six falls in June and five in July, and then four in August. Criteria for referral was likely met prior to that time based on the total number of falls during the previous year. No evidence was found of the PNMT's review of the referral until 8/28/15 (more than five days later). Due to the complexity of Individual #494's status, the PNMT should have completed a comprehensive assessment, but did not. In its response to the draft report, the State asked the Monitor to reconsider this finding and stated: "PNMT completed a comprehensive review with a root cause analysis. Issues were identified and referred to the IDT in a meeting. This issue was handled in a consultative manner." Individual #494 had numerous falls and the PNMT's review was a cursory one, with little identified as the "root cause." They did not offer recommendations designed to address the fact that he had more than 20 falls. They recommended a neurological consult, but did not follow up with findings in IPNs or meeting minutes. The IDT also placed him on one-to-one supervision and this reduced his falls, but did not address the issue as to why he might have been falling. The Monitor did not change the finding.
- For Individual #588, the PNMT assessment identified the referral date as 2/10/15. The referral stated the date as 2/4/15, although it was marked as received on 2/13/15. The first PNMT progress note was dated 3/5/15, stating the referral was on 3/4/15. The PNMT assessment was completed on 3/10/15. Due to the inconsistencies in the Facility's documentation and lack of explanation for these inconsistencies, the Monitoring Team used the 2/4/15 date as the referral date. On 7/30/15, Individual #588 died at the age of 29 with the cause of death listed as pneumonia.
- Individual #255 was referred to the PNMT in relation to a hospitalization from 7/12/15 to 7/22/15. The IDT did not make the referral until 8/5/15, when it reviewed the hospitalization. The PNMT RN attended the meeting and agreed that the PNMT would conduct an evaluation. Previous hospitalizations during the year involved referrals (January and February 2015) with no PNMT evaluation, but rather consultation only due to IDT consensus that these were not PNM-related. Hospitalizations in March and June 2015 did not result in assessments, but should have due to multiple pneumonias in the last year. As a result, Individual #255 did not receive the level of assessment necessary to meet his needs. There was limited evidence of PNMT review throughout the year. The PNMT should have conducted an assessment prior to August 2015. Moreover, there was no evidence of timely PNMT review after the individual's hospital discharges in August and October. On 11/13/15, the PNMT documented review of events from 8/1/15 to 11/3/15. This was not adequate to demonstrate that they were aware of his status and taking appropriate action, though a Comprehensive PNMT review was completed on 9/10/15, and the PNMT

reportedly reviewed it with the IDT on 9/17/15. The PNMT RN documented this sharing of information, but the IDT did not submit any further documentation. Supposedly, this sharing of information occurred during a pre-ISP meeting held on 9/17/15, but documentation to confirm this was not submitted.

- Individual #481's IDT should have referred him to the PNMT in relation to falls. His IRRF, dated 6/10/15, indicated that he would be referred to the PNMT, but there was no evidence of such a referral, despite a history of numerous falls with a serious injury on 5/7/15. At a minimum, the PNMT should have conducted a review. Without a review, justification was not present to show whether or not a PNMT Comprehensive Assessment was needed.

f. In its comments on the draft report, the State asked for explanation of why the Monitoring Team found that most individuals reviewed did not receive review/assessment with the collaboration of disciplines needed to address the identified issue. As is explained above, in most cases individuals were not referred to the PNMT, but should have been, and/or the PNMT did not complete a comprehensive assessment, but should have. As a result, a duly constituted team did not conduct a review.

e. The RN Hospitalization Review after Individual #147's right hip fracture in July 2015 was not sufficient to meet the individual's needs. For Individual #255, no RN Hospitalization Review was completed for his June 2015 hospitalization.

h. For the following individuals, Comprehensive PNMT Assessments should have been completed and/or reviews should have been completed to determine the need for a comprehensive assessments: Individual #306, Individual #494's, Individual #481's, and Individual #147. For the remaining two individuals, both assessments described the presenting problem, and included discussion of medications that might be pertinent to the problem, and discussion of their relevance to PNM supports and services. Problems with PNMT assessments varied, but in one or more the following components were missing or incomplete:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- The individual's behaviors related to the provision of PNM supports and services;
- Evidence of observation of the individual's supports at his/her program areas;
- Assessment of current physical status;
- Discussion as to whether existing supports were effective or appropriate;
- Identification of the potential causes of the individual's physical and nutritional management problems;
- Recommendations, including rationale, for physical and nutritional interventions; and
- Recommendations for measurable goals/objectives, as well as indicators and thresholds.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT	6% 1/17	0/2	0/2	0/2	0/1	0/2	1/2	0/2	0/2	0/2

	assessment/review or Physical and Nutritional Management Plan (PNMP).										
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	6% 1/17	0/2	0/2	0/2	0/1	0/2	1/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/17	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/17	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/17	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/17	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 17 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included goals/objectives related to: choking, and falls for Individual #306; aspiration, and fractures for Individual #147; choking, and falls for Individual #494; choking for Individual #227; aspiration, and skin integrity for Individual #521; falls, and aspiration for Individual #588; fractures, and aspiration for Individual #255; falls, and weight for Individual #481; and weight, and choking for Individual #532.

a. and b. The IHCP that addressed the individual's identified PNM needs as presented in the PNMP, and included preventative measures was the one for aspiration for Individual #588. In a number of cases, IDTs had not developed IHCPs to address risks and/or they were not current (e.g., choking for Individual #306; aspiration, and skin integrity for Individual #521; weight for Individual #481; and weight, and choking for Individual #532). Other ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and often did not include preventative measures to minimize the individual's condition of risk.

c. All of the PNMPs included some, but not all of the necessary components to meet the individuals' needs. On a positive note, all of the PNMPs the Monitoring Team reviewed were update/reviewed during the last 12 months; described the individual's adaptive/assistive equipment; and included individualized supports related to transfers, toileting, and oral hygiene. None of the PNMPs identified individualized triggers. Other problems varied across the PNMPs. Moving forward, the Facility should focus on ensuring PNMPs include updated photographs; individualized supports to address positioning, mobility, bathing, handling precautions, positioning during mealtimes, medication administration, and communication instructions.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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.	50% 1/2	N/A	N/A	N/A	N/A	1/1	N/A	0/1	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1					N/A		0/1		
Comments: Individual #255's IRRF did not reflect his tube placement.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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	N/A	N/A	N/A	Not Rated (N/R)	N/R	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A	N/A	N/A	N/A			N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	43% 3/7	0/1	0/1	0/1			1/1	0/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	57% 4/7	0/1	0/1	1/1			1/1	0/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A	N/A	N/A	N/A			N/A	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A			N/A	N/A	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/6	0/1	0/1	0/1			0/1	0/1	N/A	0/1
Comments: As is explained elsewhere in this report, Individual #227 and Individual #521 did not require OT/PT supports beyond PNMPs, and they were part of the outcome sample. Therefore, the Monitoring Team did not conduct review of these indicators for											

them.

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

- For Individual #306, the most current assessment submitted was dated 3/12/14. His most recent ISP was held on 3/3/15, without sufficient justification for an updated OT/PT evaluation/update not being completed.
- Individual #147 fractured his hip in July 2015, but the OT/PT did not conduct a change of status assessment. In its response to the draft report, the State asked the Monitor to change this finding, and stated: "Entry on 9/17/15 by PT - "Plan of Care for 147" – discussed short term and long term goals for 147 through PT 3-5x/week x 8 weeks beginning 9/21/15. But PT actually began on 9/17/15." In July, Individual #147 returned to Lufkin SSLC shortly after his hip fracture, but then returned to the hospital. On 9/8/15, he returned to the Infirmary. The PT stated that they would complete an assessment on 9/9/15. However, the PT essentially conducted a treatment session and the plan was limited to continue as indicated. No assessment was documented. The next IPN was on 9/14/15, and again, the PT mentioned that the plan of care a different PT developed would continue. Still no assessment was documented. Individual #147 was seen again on 9/16/15 for treatment, with no goals. Finally, on 9/17/15, the PT established goals with frequency of intervention, but still in the absence of a documented assessment. The Monitor did not change the finding.
- Although Individual #494 had a timely update for his ISP meeting held in October 2015, the OT/PT assessment did not address his change of status or report circumstances related to falls (9/9/15 and 9/10/15), the last of which resulted in a serious injury to his head, even though these had occurred prior to completion of the annual update.
- The OT and PT completed an OT/PT Update in a timely manner for Individual #255's ISP meeting. However, the assessment indicated that further assessment and updates would be completed after his return from his hospitalization. No documentation was provided to show this occurred.

d. and e. Individual #481 had a Comprehensive OT/PT Assessment. The remaining six individuals had OT/PT Updates. Problems varied across the assessment and updates, but problems were noted with five or more elements in all of the documents reviewed. Moving forward, the Facility's therapists should focus on the following elements of OT/PT assessments, and/or provision of updates to the information, as applicable to the individual:

- Discussion of 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.

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.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	71% 5/7	1/1	0/1	0/1	N/R	N/R	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	57% 4/7	0/1	1/1	0/1			1/1	1/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	11% 1/9	0/1	0/2	0/2			0/1	0/1	1/1	0/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	25% 1/4	N/A	0/1	0/2			N/A	N/A	1/1	N/A

Comments: a. Individual #147's ISP did not discuss transfer methods. Except for some skills listed as strengths, Individual #494's ISP provided no description of how the individual functions from an OT/PT perspective.

c. Individual #147's OT/PT assessment included recommended goals/objectives, but no evidence was found that the IDT reviewed them and/or incorporated them into the ISP/ISPA action plans. Other individuals had OT/PT needs for which goals/objectives and action plans should have been considered, but there was no evidence of IDT discussion and/or justification for not addressing these areas of needs through direct therapy and/or SAPs (e.g., Individual #494 reportedly was receiving OT/PT direct services, but no related goals or action steps were included in the ISP; Individual #588 had no action plan to assist him in maintaining his mobility; Individual #481 experienced falls and decline in functioning, but no action plan addressed his OT/PT needs; and a weight reduction action plan was indicated for Individual #532, but the only action step was related to calorie reduction without justification for not including an exercise program). In some cases, sufficient assessments had not been completed to determine the need for formal OT/PT supports (e.g., Individual #306 for whom an update had not been conducted, and no rationale was provided for not updating his assessment; and

Individual #255 for whom the assessment indicated that further assessment would be needed post-hospitalization, but such assessment did not appear to occur).

d. For Individual #147, as discussed above, when direct PT therapy was resumed following his most recent hip fracture, which occurred on 7/13/15, there was no assessment with an ISPA meeting to address implementation until 9/17/15. This ISPA indicated that PT would continue three to five times per week with the goals outlined.

The initiation of Individual #494's OT therapy (10/4/15) and PT therapy (10/6/15) were not discussed at ISPA meetings.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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.	100% 1/1	N/A	N/A	N/A	1/1	N/R	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	43% 3/7	0/1	1/1	1/1	N/A		1/1	0/1	0/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	38% 3/8	0/1	1/1	0/1	1/1		1/1	0/1	0/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/1	0/1	N/A	N/A	N/A		N/A	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	50% 2/4	1/1	N/A	0/1	0/1		N/A	N/A	1/1	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/4	N/A	0/1	N/A	N/A		0/1	0/1	N/A	0/1

Comments: As is explained elsewhere in this report, Individual #521 did not require formal communication supports, and she was part of the outcome sample. Therefore, the Monitoring Team did not conduct review of these indicators for her.

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

- Individual #306's ISP was held on 3/31/15, but the communication assessment was not completed until 12/10/15. His

previous communication assessment was completed in 2008. A screening conducted on 2/26/15 indicated that he required a comprehensive assessment within 30 days, but one was not completed until 12/10/15.

- Although Individual #494's comprehensive communication assessment was completed in time for his most recent ISP meeting, he had not received any previous assessments in accordance with his needs related to communication (i.e., the last one was completed in 2008).
- Individual #255's ISP meeting was held on 12/11/15, but the communication assessment was not completed until 12/30/15.
- Individual #481's ISP meeting was held on 6/10/15, but the communication assessment was not completed until 11/23/15.

c. Individual #306's screening, dated 2/26/15, lacked diagnoses, vision and hearing information, as well as discussion of medications that impact communication.

d. and e. On a very positive note, the comprehensive assessments for Individual #306 and Individual #481 included all of the necessary components and provided the IDTs with a clear picture of the individuals' preferences, strengths, and needs, as well as recommendations to assist individuals in improving their communication skills. As is noted elsewhere, it was unfortunate that the Speech Language Pathologist that completed Individual #306's assessment recommended deferral of the recommendations until the Spring of 2016 without clinical justification. Because this is addressed elsewhere and it appeared to be a decision made on the Facility-level, the Monitoring Team did not reflect this significant concern in the scoring of the assessment. However, it is important for Facility staff to note that recommendations should be based on individual's needs, not on Facility resources.

Individual #494's comprehensive assessment included many of the necessary components, but the Speech Language Pathologist identified a decline in communication abilities secondary to dementia, but did not recommend individualized strategies to address the decline related to dementia.

In all of the remaining assessments and updates reviewed, five or more of the key components were insufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should ensure communication assessments and updates address, and/or include updates, as applicable, regarding:

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

programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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.	13% 1/8	0/1	0/1	0/1	1/1	N/R	0/1	0/1	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	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.	33% 1/3	0/1	N/A	N/A	N/A		N/A	N/A	0/1	1/1

Comments: c. and d. The following are examples of problems noted:

- Individual #306's communication assessment was not completed for the ISP meeting held in March 2015. Although an ISPA meeting was held on 12/11/15 with discussion of the assessment findings, the recommendation to defer direct therapy until Spring 2016 did not reflect the needs of the individual, but rather the Facility's resources. The IDT should have required timely implementation in order to best meet the individual's needs.
- The assessment for Individual #494 did not recommended communication strategies, but should have to address increasing effects of dementia and the identified decline in communication skills.
- For Individual #227, the ISP did not include the recommended action steps for monthly review by the Speech Language Pathologist to determine readiness to resume direct therapy, and no goals were included to address participation and attention as outlined in the assessment.
- For Individual #481, although the Speech Language Pathologist recommended SAPs in the assessment dated 11/23/15, they were not integrated into the ISP via an ISPA.

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.

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	79% 19/24	3/3	1/2	2/2	2/3	2/3	1/2	3/3	2/3	3/3
3	The individual's SAPs were based on assessment results.	83% 20/24	3/3	2/2	2/2	2/3	3/3	2/2	2/3	1/3	3/3
4	SAPs are practical, functional, and meaningful.	58% 14/24	3/3	2/2	1/2	2/3	2/3	1/2	1/3	0/3	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	12% 3/24	0/3	0/2	0/2	1/3	1/3	0/2	0/3	1/3	0/3

Comments:

1. All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. There were only two SAPs for Individual #88, Individual #313, and Individual #147, for a total of 24 for this review.

2. Seventy-nine percent of the SAPs were judged to be measurable (e.g., Individual #339's walk with a guide SAP). The five SAPs that were judged not be measurable were not operationally defined (e.g., Individual #147's bathing SAP) and, therefore, could not be measured.

3. Eighty-three percent of the SAPs were based on assessment results. The four SAPs that were scored as not based on assessment results were inconsistent with functional skills assessment results (e.g., Individual #2 had a toothbrushing SAP, however, his FSA indicated he could independently brush his teeth).

4. Fifty-eight percent of the SAPs appeared to be practical and functional (e.g., Individual #176's use a microwave SAP). The SAPs that were judged not to be practical or functional typically appeared to represent a compliance issue rather than a new skill (e.g., Individual #2's wearing glasses SAP). Additionally, Individual #306's safely sit in his wheelchair SAP, appeared to be practical because Individual #306 was falling when attempting to sit in his wheelchair. At the time of onsite review, however, the Monitoring Team learned that Individual #306's medications were changed since the initiation of this SAP, and he no longer used the wheelchair. Therefore, this SAP was scored as impractical.

5. Three of the 24 SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. Several SAPs were missing

substantial amounts of data (e.g., Individual #313's identify medications SAP). The best way to ensure that SAP data are reliable is to regularly assess interobserver reliability (IOA), and assure that timely and accurate data are reported in the QIDP monthly report.

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.

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
10	The individual has a current FSA, PSI, and vocational assessment.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	67% 6/9	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:

10. Individual #339's PSI was dated April 2014.

11. Individual #88's PSI and Individual #2's vocational assessment were not available to the IDT at least 10 days prior to their ISP. The date Individual #35's PSI was available to the IDT was not tracked.

12. Individual #35's FSA did not include recommendations for skill acquisition.

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.

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.												
			Individuals:									
#	Indicator	Overall Score	2	176								
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.	50% 1/2	1/1	0/1								
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	50% 1/2	1/1	0/1								
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2	0/1	0/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2	0/1	0/1								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/2	0/1	0/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	0% 0/2	0/1	0/1								

	them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2	1/1	1/1							
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 2/2	1/1	1/1							
26	The PBSP was complete.	N/A	N/A	N/A							
27	The crisis intervention plan was complete.	100% 2/2	1/1	1/1							
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	50% 1/2	0/1	1/1							
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	50% 1/2	1/1	0/1							

Comments:
18-29. This outcome and its indicators applied to Individual #2 and Individual #176.

18. Individual #2 had his fourth restraint in 30 days on 8/5/15, and his ISPA met on 8/14/15 to address these restraints. Individual #176, however, had four restraints in September 2015, however, no ISPA to address more than three restraints in 30 days was available.

19. A sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days for Individual #2, however, no ISPAs to address more than three restraints in 30 days were provided for Individual #176.

20. Individual #2's ISPA following more than three restraints in 30 days had discussions of adaptive skills, and biological, medical, and/or psychosocial issues that potentially contributed to his restraints, however, the minutes of the ISPA did not include actions to address these potential contributing variables in the future. Individual #176 did not have an ISPA to address more than three restraints in 30 days.

21. Individual #2's ISPA following more than three restraints in 30 days did not reflect a discussion of contributing environmental variables (e.g., setting events such as noisy environments). Individual #176 did not have an ISPA to address more than three restraints in 30 days.

22. Individual #2's ISPA included a discussion of potential antecedent conditions that potentially contributed to his restraints, however no actions to address those antecedent conditions was evident. Individual #176 did not have an ISPA to address more than three restraints in 30 days.

23. Individual #2's ISPA reflected a discussion among the IDT of potential maintaining variables (e.g., staff attention, access to tangibles), however, no plans of how to address these issues in the future. Individual #176 did not have an ISPA to address more than three restraints in 30 days.

24. Both Individual #2 and Individual #176 had current PBSPs.

25 and 27. Both Individual #2 and Individual #176 had complete crisis intervention plans.

28. Individual #176 had treatment integrity data in October of 2015 indicating that her PBSP was implemented with integrity. Individual #2 did not have any treatment integrity data.

29. Individual #2's ISPA indicated that his IDT reviewed his PBSP and found it to be effective. Individual #176 did not have an ISPA to address more than three restraints in 30 days.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
1	If not receiving psychiatric services, a Reiss was conducted.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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.	100% 3/3	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	67% 2/3	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

1. For the 16 individuals reviewed by both Monitoring Teams, all but two of the individuals were receiving psychiatric services. These two individuals were part of the group selected by the medical-physical Monitoring Team. These two individuals both received Reiss screens and further psychiatric evaluation was not necessary.

2-3. In addition, there were two individuals from this group (Individual #494, Individual #227) who had Reiss screens performed for a change of status. This was good to see. A Reiss screen for change of status was also performed for Individual #147, according to notes in his record, however, despite two document requests, the results were not located. As such, it was not possible to determine if a CPE was completed for within 30 days of the referral. Even so, this individual received and was continuing to receive psychiatric services at the time of the onsite review.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 6/6	1/1	1/1	1/1	N/A	N/A	N/A	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 7/7	1/1	1/1	1/1	N/A	1/1	N/A	1/1	1/1	1/1

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

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented. For Individual #306, it was noted that in addition to medication recommendations, specific individualized non-pharmacological interventions, including walking, playing ball, throwing horseshoes, and verbal praise, were recommended. This was good to see. For Individual #2, although medication adjustments had been made, it was considered that in the absence of appropriate diabetes management, mental health stability would be difficult to achieve.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	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.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:
23. Although the derivation was consistent in both the structural/functional behavioral assessment and the psychiatric documentation, there were concerns regarding the validity of target symptoms identified. In general, the target symptoms did not correspond with specific diagnoses.

24. There was indication of psychiatric participation in the development of the PBSP. PBSP documents (e.g., functional behavioral assessment) revealed that psychiatric documentation was in the final report. Furthermore, psychiatric documentation included recommendations regarding behavioral supports.

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.

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	60% 3/5	N/A	1/1	0/1	N/A	1/1	N/A	N/A	0/1	1/1
26	Frequency was at least annual.	75% 3/4	N/A	1/1	0/1	N/A	1/1	N/A	N/A	N/A	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	20% 1/5	N/A	1/1	0/1	N/A	0/1	N/A	N/A	0/1	0/1

Comments:
25-27. This outcome addresses the coordination between psychiatry and neurology. These indicators applied to five of the individuals. There was detailed psychiatric documentation of neurology consultation in the record of Individual #147, Individual #306, and Individual #176. Unfortunately, neurology documentation was brief and did not include information regarding collaboration with psychiatry.

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

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
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	N/A	N/A	N/A	1/1	N/A	1/1	N/A	1/1	N/A

Comments:
33. Individuals were seen quarterly in a timely manner.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing two components: a

review of the implementation of non-pharmacological interventions and the attendance sign in sheet.

35. Psychiatry clinic was observed for Individual #35, Individual #88, and Individual #2. The psychiatry clinics were thorough and detailed, including a review of pertinent laboratory examinations, other assessments, and data.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	22% 2/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1
Comments: 36. For the most part, these evaluations were completed, but there were delays in the physician's reviews and signatures. In some cases, such as Individual #339, Individual #313, and Individual #306, psychiatry documentation indicated that the evaluations were occurring in a timely manner, however, the document request response submission was incomplete regarding the original assessment.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
Comments: 37-39. There was evidence of frequent additional psychiatric reviews when an individual was clinically unstable.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
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	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	staff convenience, or as a substitute for treatment.	9/9									
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
40-41. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment.

43. The facility did not use PEMA.

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.

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 4/4	N/A	N/A	1/1	1/1	N/A	N/A	N/A	1/1	1/1
45	There is a tapering plan, or rationale for why not.	100% 4/4	N/A	N/A	1/1	1/1	N/A	N/A	N/A	1/1	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	50% 2/4	N/A	N/A	1/1	0/1	N/A	N/A	N/A	0/1	1/1

Comments:
44-45. These indicators applied to four individuals. Polypharmacy justification was cogent and appropriate. The five other individuals reviewed had reductions in psychiatric medications but did not meet the criterion for polypharmacy. These medication reductions were good to see.

46. The facility has regular polypharmacy committee meetings. Documentation indicated good reviews of the regimens prescribed to Individual #313 and Individual #176. There was no documentation of reviews for Individual #2 or Individual #35. Given the complexity of Individual #2's case (i.e., psychiatric and medical issues), more expedient review would be expected.

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.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
6	The individual is making expected progress	13% 1/8	0/1		0/1	1/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 6/6	N/A		1/1	N/A	1/1	1/1	1/1	1/1	1/1
9	Activity and/or revisions to treatment were implemented.	100% 6/6	N/A		1/1	N/A	1/1	1/1	1/1	1/1	1/1

Comments:
6. Individual #35's progress note data indicated that he was making progress on the objectives in the PBSP. Available data indicated that Individual #313, Individual #306, Individual #88, Individual #7, Individual #2, and Individual #176 were not making progress. Individual #339's progress notes indicated he was progressing, however, because his data were unreliable, he was not scored as progressing.

8-9. Individual #313, Individual #306, Individual #88, Individual #7, Individual #2, and Individual #176 were not making progress, however, their progress notes included actions to address the absence of progress. Additionally, there was evidence that these actions were implemented.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
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.	14% 1/7	1/1		0/1		0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	100% 7/7	1/1		1/1		1/1	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 7/7	1/1		1/1		1/1	1/1	1/1	1/1	1/1

Comments:

16. Only Individual #339 had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing his PBSP were trained on the its implementation.

17. Lufkin SSLC utilized a brief PBSP for all individuals.

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

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
19	The individual's progress note comments on the progress of the individual.	100% 7/7	1/1		1/1		1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	100% 7/7	1/1		1/1		1/1	1/1	1/1	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 2/2	N/A	1/1	N/A		N/A	N/A	1/1	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 2/2	N/A		N/A		N/A	N/A	N/A	N/A	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

Comments:

19-20. All individuals had progress notes and graphed PBSP data that lent themselves to visual interpretation, and included indications of the occurrence of important environmental changes (e.g., medication changes).

21. In order to score this indicator, the Monitoring Team observed Individual #147's psychiatric clinic meeting and Individual #7's peer review. In both meetings, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team.

22. None of the nine individuals chosen by the Monitoring Team had peer review in the last six months,, so Individual #299 and Individual #227 were reviewed in order to rate this indicator. There was evidence of follow-up/implementation of recommendations from both of their peer reviews.

23. The Monitoring Team observed Individual #7's internal peer review. Individual #7 was reviewed because he had not been progressing as expected. His peer review included the review of his functional assessment and PBSP. There was participation and discussion by the behavioral health services team to improve his PBSP. Lufkin SSLC had documentation that internal peer review meetings were consistently occurring weekly, and that external peer review meetings were occurring monthly.

Outcome 8 – Data are collected correctly and reliably.

			Individuals:								
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 7/7	1/1		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% 7/7	1/1		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% 7/7	1/1		1/1		1/1	1/1	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 7/7	1/1		1/1		1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	43% 3/7	1/1		0/1		1/1	1/1	0/1	0/1	0/1

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

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

29. Lufkin SSLC established that data collection timeliness, IOA, and treatment integrity would occur at least quarterly and at a level of at least 80% for all individuals with a PBSP. Additionally, the facility established that if an individual had a crisis intervention plan (CIP), data collection timeliness, IOA, and treatment integrity would be collected monthly.

30. Goal frequencies and levels of data collection timeliness, IOA, and treatment integrity were achieved for Individual #339, Individual #306, and Individual #88. Individual #313 did not have treatment integrity assessed this quarter, and the last assessment of Individual #7's data collection timeliness was under 80%. Individual #2 and Individual #176 had CIPs, and Individual #2 did not have IOA, data collection timeliness, or treatment integrity in the last month. Individual #176 did not have IOA or treatment integrity in the last two months.

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.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	19% 3/16	1/2	1/2	1/2	0/2	N/A	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.	6% 1/16	0/2	0/2	0/2	1/2	N/A	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	0/2	0/2	0/2	N/A	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	0/2	0/2	0/2	N/A	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	0/2	0/2	0/2	N/A	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 #306 – seizures, and constipation/bowel obstruction; Individual #147 – osteoporosis, and constipation/bowel obstruction; Individual #494 – seizures, and osteoporosis; Individual #227 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #521 – seizures, and respiratory compromise; Individual #588 – gastrointestinal problems, and aspiration; Individual #255 – respiratory compromise, and osteoporosis; Individual #481 – seizures, and hypertension; and Individual #532 – osteoporosis, and other: hypothyroidism). For Individual #521 – seizures, and respiratory compromise, all goals and action plans were discontinued due to hospice services.

From a medical perspective, the goals that were clinically relevant and achievable, but not measurable were the ones for Individual #306 – constipation/bowel obstruction; Individual #147 – constipation/bowel obstruction; and Individual #494 –osteoporosis. The one that was measurable, but not clinically relevant/achievable was the one for Individual #227 – UTIs.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
g.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 3/3	N/A	N/A	1/1	N/A	N/A	N/A	1/1	1/1	N/A
	iii. Breast cancer screening	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	88% 7/8	1/1	1/1	1/1	N/A	0/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
h.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1

Comments: g.i. through g.v.ii. The following concerns were noted:

- For Individual #306, there was no documentation of pneumococcal conjugate (PCV13) vaccination, or justification for not providing it. Per Centers for Disease Control guidelines, this vaccination is recommended for individuals two to 64 years of age with underlying medical conditions such as chronic kidney disease and all adults 65 years of age and older.
- For Individual #521, her Hepatitis B surface antibody was reported as negative in the annual medical assessment, but this was not addressed. In April 2015, a mammogram showed asymmetric density in right breast. Additional views were recommended, but no documentation of this was present in the record (even prior to Individual #521 being placed in hospice care). No DEXA was completed for this individual with multiple risk factors.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	Individual with DNR that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	50% 1/2	N/A	N/A	N/A	N/A	0/1	N/A	1/1	N/A	N/A
Comments: The DNR Order for Individual #521 was implemented on 5/30/13. The Facility submitted a copy of the active problem list for justification indicating that the qualifying diagnosis in 2013 was respiratory insufficiency. This was not adequate justification for a DNR Order. At the time of the onsite review, Individual #521 was receiving hospice services since July 2015.											

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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.	17% 1/6	0/1	N/A	0/1	0/1	N/A	0/1	N/A	0/1	1/1

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.	17% 1/6	0/1		0/1	0/1		0/1		0/1	1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	50% 6/12	1/2	1/2	2/2	N/A	0/2	0/1	1/2	1/1	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 2/4	N/A	0/1	1/1		N/A	0/1	1/1	N/A	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	92% 11/12	2/2	2/2	2/2		2/2	0/1	2/2	1/1	
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 12/12	2/2	1/2	2/2		2/2	1/1	2/2	1/1	
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	78% 7/9	1/1	1/2	2/2		1/2	N/A	2/2	N/A	
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.	45% 5/11	2/2	2/2	0/2		0/2	N/A	0/2	1/1	

Comments: a. and b. For the six of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed six acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #306 (neutropenia on 10/16/15), Individual #494 (rash on 7/20/15), Individual #227 (cellulitis of eyelids on 9/8/15), Individual #588 (recurrent emesis on 7/24/15), Individual #481 (rule out gastrointestinal bleed on 5/22/15), and Individual #532 (tinea pedis on 8/6/15).

For the following acute issue, the medical provider at Lufkin SSLC followed accepted clinical practice in assessing it, and documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #532 (tinea pedis on 8/6/15).

The following provide a few examples of some of the problems noted with regard to the assessment and/or treatment of individuals at

Lufkin SSLC:

- Individual #306 had a history of neutropenia. On 10/16/15, the PCP noted "critical lab values" indicating neutropenia. The plan did not include monitoring for signs and symptoms of infection/illness. There was no documentation of vital signs, such as temperature or a physical examination. On 10/21/15, another PCP documented a physical exam. The next PCP documentation was not until 11/19/15. At that time, the PCP noted the absolute neutrophil count of less than 500 and indicated that Neupogen was started the previous day. It was documented that there was no fever or illness. There was no further documentation for this very serious issue.
- On 7/20/15, the PCP evaluated Individual #494 due to frequent falls, and noted the individual had a fine macular rash. Lamotrigine had been recently started and was, therefore, discontinued due to the rash. On 7/21/15, the individual was seen again after being evaluated in the ED for falls. It was noted that the rash was fading. However, there was no further follow-up for the rash, which was reported to the Federal Drug Administration as an adverse drug reaction.
- On 9/8/15, the PCP evaluated Individual #227 and documented swollen eyelids and red conjunctiva. The diagnosis was cellulitis of the eyelids. Augmentin was prescribed for 10 days. There was no follow-up evaluation.
- Individual #588 had more than 30 episodes of emesis from 5/1/15 to 7/21/15. On 7 /24/15, the PCP was notified that the individual had four episodes of emesis. Phenergan was ordered. The PCP did not conduct an assessment. The emesis continued, and as noted below, on 7/27/15, he was transferred to the hospital. On 7/30/15, Individual #588 died with the cause of death listed as pneumonia.
- On 5/22/15, the PCP documented in a brief four-line note that blood was noted in Individual #481's stool, but not in his underwear. The assessment was possible gastrointestinal bleed. A complete blood count (CBC) and stool for occult blood times three was ordered. The PCP did not document a physical examination or assessment. Vital signs were also not documented. There was no follow-up assessment related to this complaint, and no documentation of the results of the diagnostics. This management is not consistent with guidelines recommended by organizations such as the American College of Physicians, or the American College of Gastroenterology Practice Guidelines.

The Monitoring Team reviewed 12 acute illnesses requiring Infirmary admission, hospital admission, or ED visit, including the following with dates of occurrence: Individual #306 (seizures on 10/9/15, and laceration on 9/2/15), Individual #147 (wound infection/bacteremia on 7/31/15, and fever evaluation on 7/30/15), Individual #494 (evaluation of a fall on 9/10/15, and unresponsiveness on 5/6/15), Individual #521 [Methicillin-resistant Staphylococcus aureus (MRSA) pneumonia on 7/22/15, and transfer to hospital for respiratory distress on 10/17/15], Individual #588 (recurrent emesis on 7/27/15), Individual #255 (septic shock on 9/20/15, and MRSA pneumonia on 8/9/15), and Individual #532 (laceration on 5/7/15).

c. For the following Infirmary admission, hospital admission, or ED visit, the PCP or a provider timely evaluated the individual prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provided an IPN with a summary of events leading up to the acute event and the disposition: Individual #306 (seizures on 10/9/15), Individual #147 (fever evaluation on 7/30/15), Individual #494 (evaluation of a fall on 9/10/15, and unresponsiveness on 5/6/15), Individual #255 (MRSA pneumonia on 8/9/15), and Individual #532 (laceration on 5/7/15).

d. Eight of the acute illnesses reviewed occurred after hours or on a weekend/holiday. For the remaining acute illnesses, quality assessments were documented in the IPNs for Individual #494 (unresponsiveness on 5/6/15), and Individual #255 (MRSA pneumonia

on 8/9/15).

e. For the acute illnesses reviewed, it was positive the individuals generally received timely treatment at the SSLC. The exception was Individual #588 (recurrent emesis on 7/27/15).

f. It was also positive that for the individuals reviewed that were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff.

g. The individuals for whom IDTs did not meet and develop post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness included: Individual #147 (wound infection/bacteremia on 7/31/15), and Individual #521 (transfer to hospital for respiratory distress on 10/17/15).

h. Individual #588 died in the hospital, so follow-up was not applicable. Sufficient follow-up was conducted for Individual #306 (seizures on 10/9/15, and laceration on 9/2/15), Individual #147 (wound infection/bacteremia on 7/31/15, and fever evaluation on 7/30/15), and Individual #532 (laceration on 5/7/15).

The following are examples of problems identified with medical care provided for the acute medical conditions:

- On 8/8/15, Individual #255 was seen in the ED and diagnosed with early pneumonia and returned to the Facility. On 8/9/15, the PCP evaluated the individual and noted respiratory distress and hypoxia. The individual was transferred to the hospital again and admitted with MRSA multi-lobar pneumonia. On 8/25/15 at 11:45 a.m., he returned to the Facility. On 8/26/15 at 4:30 p.m., the PCP saw him. The next PCP documentation was on 9/4/15, when the PCP documented that the chest x-ray continued to show bibasilar infiltrates. Levaquin was prescribed for 10 days. There was no follow-up PCP documentation. On 9/20/15, nursing staff documented that the individual was hypothermic with decreased oxygen saturation. He was transferred to the hospital for evaluation, and admitted with septic shock, and bilateral pneumonia. On 10/2/15, the individual returned to Facility. The PCP did not conduct a follow-up evaluation until 10/5/15. The next PCP note was dated 10/14/15. This note documented that the family requested a DNR. The medical justification was not documented. There was no further follow-up documented. On 11/4/15, the PCP made an entry, which was after the individual returned from the 10/26/15 hospitalization. On 11/12/15, an addendum was made noting that the medical justification for the DNR was chronic respiratory failure.
- From 5/1/15 to 7/24/15, Individual #588's IPNs documented significant emesis, but there was never any assessment by a medical provider. As noted above, on 7/24/15, Individual #588's PCP was notified of four episodes of emesis, and ordered medication without conducting an assessment. On 7/27/15, the PCP requested transfer of the individual to the hospital for evaluation due to daily emesis. The individual had marked electrolyte abnormalities, pneumonia, and respiratory failure. The family elected to transfer the individual to hospice with a DNR Order. On 7/30/15, Individual #588 died at the age of 29 with the cause of death listed as pneumonia.
- On 5/6/15, Individual #494 was admitted to hospital with diagnosis of new onset seizures. Upon his discharge on 5/8/15, the PCP saw him and noted that Keppra was started and the individual would be seen in Neurology clinic in one month. There was no additional follow-up. The next PCP note was on 7/2/15, which was a follow-up for an ED visit on 7/1/15 due to a fall.
- On 9/10/15, Individual #494 was sent to the ED in the morning for evaluation of a fall. Nursing staff documented that the individual was found on the floor with a purple color to face and having a seizure. After his return to the Facility on 9/10/15,

the PCP saw him. The PCP documented a large area of ecchymosis, right periorbital contusion, and chest wall abrasion. The PCP ordered a chest x-ray, x-ray of the facial bones, and C-spine along with a Trileptal level. On 9/11/15, the PCP noted the individual would be seen in clinic on 9/14/15 for follow-up of x-rays. On 9/16/15, Individual #494 was seen in clinic for evaluation of a rash. There was no documentation of the results of the x-rays and CT of the hips, which was also ordered.

- On 7/23/15, Individual #521 was admitted to the hospital with MRSA pneumonia and respiratory failure. On 7/29/15, she was transferred to inpatient hospice, and on 8/7/15, she returned to the Facility, and the PCP evaluated her. The next PCP note was dated 9/1/15. This note indicated that the Facility was assuming responsibility for hospice services. There was no additional PCP documentation until 10/23/15. In the meantime, on 10/14/15, Individual #521 was sent to the ED and returned. Again on 10/17/15, she was sent to the hospital, and admitted with respiratory distress. On 10/23/15, she returned to the Facility. The PCP evaluated the individual on 10/23/15, and daily until 10/26/15. After her discharge from the Infirmary on 10/26/15, there was no further PCP documentation.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	79% 11/14	1/2	2/2	1/2	1/1	2/2	N/A	1/1	1/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	64% 9/14	1/2	2/2	1/2	1/1	1/2		0/1	1/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	79% 11/14	1/2	2/2	1/2	1/1	2/2		1/1	1/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	90% 9/10	1/1	1/1	1/1	1/1	2/2		1/1	1/1	1/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 14 consultations. The consultations reviewed included those for Individual #306 for neurology on 10/22/15, and hematology/oncology on 7/29/15; Individual #147 for neurology on 6/25/15, and surgery on 9/30/15; Individual #494 for ophthalmology on 10/16/15, and cardiology on 9/29/15; Individual #227 for gynecology on 10/28/15; Individual #521 for ophthalmology on 5/20/15, and pulmonary on 6/23/15; Individual #255 for neurology on 9/9/15; Individual #481 for neurology on 7/8/15, and ophthalmology on 5/6/15; and Individual #532 for neurology on 10/14/15, and gynecology on 6/18/15.

a. PCPs did not review and/or initial consultation reports, and indicate agreement or disagreement with the recommendations for

Individual #306 for neurology on 10/22/15, Individual #494 for cardiology on 9/29/15, and Individual #481 for ophthalmology on 5/6/15.

b. The reviews for which documentation was not present to show they were completed timely were those for Individual #306 for neurology on 10/22/15, Individual #494 for cardiology on 9/29/15, Individual #521 for ophthalmology on 5/20/15, Individual #255 for neurology on 9/9/15, and Individual #481 for ophthalmology on 5/6/15.

c. The consultations for which the PCP did not write a corresponding IPN that included the information that State Office policy requires were for Individual #306 for neurology on 10/22/15, Individual #494 for cardiology on 9/29/15, and Individual #481 for ophthalmology on 5/6/15. Individual #494 was referred to cardiology for evaluation of possible syncope. Cardiology made recommendation to check event monitor, carotid ultrasound and magnetic resonance angiography (MRA) of the brain. No IPN was found related to this consultation. An order was written for a follow-up cardiology appointment in two months. However, the results of the recommended studies were not in the record.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show they were ordered (in some instances, orders were not found for all agreed upon recommendations) for the following: Individual #532 for gynecology on 6/18/15. The consultant recommended that an estradiol level be obtained noting that medroxyprogesterone might contribute to osteopenia. The estradiol level was ordered, but there was no documentation of the results or follow-up related to the recommendation.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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.	56% 10/18	2/2	2/2	2/2	2/2	0/2	0/2	0/2	1/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #306 – seizures, and constipation/bowel obstruction; Individual #147 – osteoporosis, and constipation/bowel obstruction; Individual #494 – seizures, and osteoporosis; Individual #227 – constipation/bowel obstruction, and UTIs; Individual #521 – seizures, and respiratory compromise; Individual #588 – gastrointestinal problems, and aspiration; Individual #255 – respiratory compromise, and osteoporosis; Individual #481 – seizures, and hypertension; and Individual #532 – osteoporosis, and other: hypothyroidism).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #306 – seizures, and constipation/bowel obstruction; Individual #147 – osteoporosis, and constipation/bowel obstruction; Individual #494 – seizures, and osteoporosis; Individual #227 – constipation/bowel obstruction, and UTIs; Individual #481 – seizures; and Individual #532 – other: hypothyroidism.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	56% 9/16	1/2	2/2	1/2	2/2	N/A	0/2	1/2	1/2	1/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. The action steps assigned to the PCPs for the individuals reviewed that were implemented were those for: Individual #306 – constipation/bowel obstruction; Individual #147 – osteoporosis, and constipation/bowel obstruction; Individual #494 –osteoporosis; Individual #227 – constipation/bowel obstruction, and UTIs; Individual #255 – osteoporosis; Individual #481 – seizures; and Individual #532 – other: hypothyroidism.

The following describe some of the concerns related to the implementation of medical interventions at Lufkin SSLC:

- On 9/24/15, the neurologist saw Individual #306 and made the recommendation to optimize Trileptal. A complete blood count was not documented in the consult. On 10/22/15, the individual was seen again due to neutropenia attributed to Depakote use. The recommendation was to wean him off Depakote and start Onfi. This individual had a history of neutropenia. The IRRF noted that antiepileptic drugs were likely responsible for the neutropenia. However, this was not addressed until the October 2015 evaluation when a "critically low ANC [absolute neutrophil count]" was documented.
- On 5/6/15, Individual #494 experienced a possible seizure or syncopal episode. He was evaluated in the hospital and started on Keppra. An electroencephalogram (EEG) could not be done. The Keppra was discontinued due to agitation. Lamotrigine was started and subsequently discontinued due to the development of a rash. The individual was started on oxcarbazepine. Another seizure was reported. A cardiology referral was done and recommendations were made to obtain a brain MRA, carotid ultrasound, and event monitor. There was no documentation of this evaluation being completed.
- Individual #521 did not have active treatment plans, because she was on hospice. However, review of her records raised questions. Per the November 2015 IRRF, this individual had 275 documented seizures in 2014 and required 24 pro re nata (PRN, or as needed) doses of Diastat. At the time of the IRRF, the individual had 139 seizures over the past year, and required 17 PRN doses of Diastat. The improvement was attributed to the addition of the medication Onfi. During a recent hospitalization, an EEG was done and the diagnosis of Lennox-Gastaut was made. Because hospice services were initiated, all future neurology appointments and lab monitoring were discontinued. It is not clear why an individual with 275 documented seizures only recently had an EEG and was determined to have Lennox-Gastaut syndrome. There were no neurology consults available in the record.

  In addition, according to the IRRF, the pneumonia review process at the Facility did not confirm the diagnosis of pneumonia for the past year. However, Individual #521 was admitted to the hospital multiple times, evaluated by pulmonary and diagnosed with pneumonia. It was unclear why the Facility staff disregarded these external diagnoses. A lack of recognition of diagnosed pneumonia impacts the implementation of specific strategies to assist in preventing pneumonia in the future.
- Individual #588's IRRF indicated the IDT rated him at medium risk for aspiration. The modified barium swallow study (MBSS),

done on 4/2/14, demonstrated silent aspiration and the individual was provided a modified diet. However, the IRRF did not discuss his recurrent emesis and how this problem would increase the risk for aspiration. The AMA included no discussion of aspiration risk based on an individual with a history of silent aspiration and recurrent emesis. On 2/25/15, an esophagogastroduodenoscopy (EGD) was done and no specific etiology for the emesis was determined. Gastroenterology noted that the majority of the individual's stomach was in his chest. The AMA documented that a general surgery consult was completed on 5/13/14. The recommendation was to consult a thoracic surgeon for repair of the hiatal hernia. The AMA provided no documentation of consultation with a thoracic surgeon. It did not provide any discussion related to why surgical repair of the hiatal hernia was not further discussed/pursued. On 7/30/15, Individual #588 died at the age of 29 with the cause of death listed as pneumonia.

- For Individual #255, the PCP documented very little in the AMA regarding the supports related to recurrent pneumonia. He had multiple admissions to the hospital from June to September 2015 for pneumonia, septic shock, and dehydration. The pulmonary consultant noted dehydration was a contributing factor and the use of a gastric tube, which he had, should allow for proper hydration at the Facility. On 9/30/15, inhaled tobramycin was started for pneumonia prevention per the recommendation of the clinical pharmacist. This drug is FDA-approved for management of pseudomonas infections in cystic fibrosis patients. It may also be used in the management of ventilator patients. The pulmonologist provided a discontinuation date of 7/29/15, following discharge. Long-term use is associated with antibiotic resistance. Subsequent hospital discharge summaries did not list this medication for continued use. It would seem prudent to seek consultation with the pulmonologist if long-term use is implemented. Montelukast was also recommended for pneumonia prevention. This drug is approved for treatment of asthma, allergic rhinitis, and exercise-induced bronchospasm. It was unclear if the pulmonologist made a recommendation for long-term use for pneumonia prevention.
- Per Individual #481's AMA, his blood pressure was well controlled and monitored daily. Individual #481 was to see the cardiologist annually and as needed. The plan did not include specific monitoring for target-organ damage and cardiovascular disease, such as renal function, urinalysis for protein, and electrocardiogram (EKG). An IPN note documented an abnormal EKG on 6/3/15, noting that the changes were not new. There was no cardiology consult in the active records and no order to schedule an appointment.

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; any necessary additional laboratory testing is completed 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.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2

b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	33% 1/3	N/A	N/A	0/2	N/A	N/A	1/1	N/A	N/A	N/A

Comments: b. The following problems were noted:

- For Individual #494,
  - There was no intervention for the use of midazolam (i.e., Versed). Versed by mouth should be used in monitored settings. It has a short half-life, so administering it 30 minutes prior to leaving for an appointment might not be effective. Clarification of this order should have occurred.
  - The instructions were to give the Hepatitis vaccine as directed by pharmacy. The pharmacy does not have vaccine protocols, and there was no intervention or clarification.

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.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	QDRRs are completed quarterly by the pharmacist.	61% 11/18	2/2	1/2	1/2	0/2	2/2	1/2	1/2	2/2	1/2

b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	50% 7/14	1/2	2/2	1/1	1/1	2/2	0/1	0/1	0/2	0/2
	ii. Benzodiazepine use;	100% 8/8	2/2	2/2	N/A	1/1	2/2	N/A	1/1	N/A	N/A
	iii. Medication polypharmacy;	82% 9/11	2/2	0/2	N/A	1/1	2/2	N/A	N/A	2/2	2/2
	iv. New generation antipsychotic use; and	100% 10/10	2/2	1/1	N/A	1/1	N/A	1/1	1/1	2/2	2/2
	v. Anticholinergic burden.	100% 8/8	2/2	1/1	N/A	1/1	1/1	N/A	1/1	N/A	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% 14/14	2/2	2/2	1/1	1/1	2/2	1/1	1/1	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 10/10	2/2	2/2	1/1	1/1	N/A	1/1	1/1	N/A	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	100% 9/9	2/2	2/2	1/1	1/1	N/A	N/A	N/A	2/2	1/2

Comments: a. The Monitoring Team requested the last two QDRRs for nine individuals. It was concerning that for six of the nine individuals, QDRRs had not been completed quarterly.

b. The following provide examples of concerns noted:

- Individual #306 had Chronic Kidney Disease Stage II, but there was no mention of this in the QDRR. Glomerular filtration rate should have been noted. He did not have yearly follow-up with renal. His creatinine was at the upper limits of normal and urine protein was over the upper limits.
- For Individual #147, his most recent QDRR, dated 10/31/15, did not mention the use of polypharmacy related to bowel management. The individual received four medications, one of which was a suppository that was given on a continual basis.
- For Individual #588, the comments section of the 4/20/15 QDRR listed a series of diagnoses, but offered no information even though in several cases, the individual received a medication for treatment of the condition. No lab values were documented, including no vitamin D level even though the individual was treated for a Vitamin D deficiency.
- For Individual #255, the 8/18/15 QDRR included no labs/diagnostics. For example, the individual was treated for

osteoporosis, but there was no comment on the effectiveness. The DEXA showed decreasing bone mineral density.

- For Individual #481, the 8/12/15 QDRR included no comments related to medical conditions that required medication, specifically hyperlipidemia and hypertension. The individual's lipid values were not at target and there was no documentation of the monitoring for hypertension. Similarly, the 5/21/15 QDRR indicated that an electrocardiogram (EKG) was "N/A." However, the individual has hypertension making monitoring of EKG important. DEXA was also stated to be "N/A," but the individual was prescribed anti-epileptic drugs associated with loss of bone density.
- For Individual #532, a recommendation was made regarding the use of calcium for osteoporosis. However, the QDRR did not discuss the use of Prolia and its effectiveness. The effect of the medroxyprogesterone on bone mineral density was also not addressed in this individual with osteoporosis in both femoral necks.

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

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.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed nine individuals with medium or high dental risk ratings. None of the individuals had clinically relevant, achievable, and measurable goals related to their dental health.

c. through e. In addition to a lack of clinically relevant, achievable, and measurable goals/objectives, progress reports on goals/objectives, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult

to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these nine individuals.

Outcome 4 – Individuals maintain optimal oral hygiene.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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.	33% 3/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	67% 6/9	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	44% 4/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	57% 4/7	0/1	0/1	1/1	1/1	N/A	1/1	N/A	1/1	0/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									

Comments: a. At the time of the onsite review, Individual #521 was edentulous, but had prophylactic care within the review period prior to becoming edentulous.

c. Because the type of x-ray was not documented for a number of individuals, the Monitoring Team could not confirm that these individuals had x-rays completed in accordance with the identified standards.

Outcome 6 – Individuals receive timely, complete emergency dental care.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									

b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: None of the individuals that the Monitoring Team responsible for the review of physical health reviewed had dental emergencies in the six months prior to the review.											

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 4/4	N/A	1/1	N/A	N/A	1/1	1/1	1/1	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 4/4		1/1			1/1	1/1	1/1		
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	75% 3/4		0/1			1/1	1/1	1/1		
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% 0/4		0/1			0/1	0/1	0/1		
Comments: None.											

Outcome 8 – Individuals who need them have dentures.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	50% 4/8	0/1	0/1	1/1	N/A	1/1	0/1	1/1	0/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: As noted in the Monitoring Team's previous report, the Annual Dental Exam template did not include a denture assessment. The Dental Director indicated that historically, a denture assessment was documented only for those who were fully edentulous. This practice was recently changed to include an assessment of the need for prosthesis in all individuals with missing teeth.											

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.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	54% 7/13	0/2	2/2	1/2	0/1	2/2	0/1	1/2	1/1	N/A
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.	50% 6/12	0/2	2/2	0/1	0/1	2/2	0/1	1/2	1/1	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	25% 1/4	0/1	N/A	1/1	0/1	N/A	N/A	0/1	N/A	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	44% 4/9	0/1	2/2	0/1	N/A	0/2	0/1	1/1	1/1	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/13	0/2	0/2	0/2	0/1	0/2	0/1	0/2	0/1	
f.	The individual's acute care plan is implemented.	0% 0/13	0/2	0/2	0/2	0/1	0/2	0/1	0/2	0/1	

Comments: The Monitoring Team reviewed 13 acute illnesses and/or acute occurrences for eight individuals, including Individual #306 – swelling to lip on 5/13/15, and multiple uncontrolled seizures with decreased level of consciousness on 10/9/15; Individual #147 – frequent cough and hypercapnia on 7/30/15, and right upper lobe pneumonia (with added diagnoses of severe iron anemia, and MRSA surgical wound infection) on 7/31/15; Individual #494 – pharyngitis on 10/6/15, and large frontal scalp hematoma and abrasion and constipation on 9/10/15; Individual #227 – cellulitis of left eyelid on 9/8/15; Individual #521 – respiratory insufficiency and pneumonia on 6/24/15, and pneumonia (organism MRSA) on 7/23/15; Individual #588 – vomiting for three days (with hospital discharge diagnoses of right lung pneumonia, respiratory failure, and chronic capnic respiratory failure) on 7/27/15; Individual #255 – hypoxia (with hospital discharge diagnoses of bilateral pneumonia, hypothermia, and hypoxemia) on 7/12/15, and status post pneumonia bibasilar infiltrates on 9/14/15; and Individual #481 – fall with laceration on 5/7/15. The Facility did not submit any acute care plans for Individual #532.

a. The signs and symptoms of acute illnesses/occurrences for which nursing assessments were performed included Individual #147 – frequent cough and hypercapnia on 7/30/15, and right upper lobe pneumonia on 7/31/15; Individual #494 – pharyngitis on 10/6/15;

Individual #521 – respiratory insufficiency and pneumonia on 6/24/15, and pneumonia (organism MRSA) on 7/23/15; Individual #255 – hypoxia on 7/12/15; and Individual #481 – fall with laceration on 5/7/15.

b. As discussed below, this indicator was not applicable for Individual #494's ED visit on 9/10/15. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #147 – frequent cough and hypercapnia on 7/30/15, and right upper lobe pneumonia on 7/31/15; Individual #521 – respiratory insufficiency and pneumonia on 6/24/15, and pneumonia (organism MRSA) on 7/23/15; Individual #255 – hypoxia on 7/12/15; and Individual #481 – fall with laceration on 5/7/15. At times, physicians were notified, but information was inadequate to meet the individual's needs based on the event, the individual's current health status and the risk.

For Individual #494 for the 9/10/15 ED visit for a large frontal scalp hematoma, the Nursing IPN stated "trying to get 8500 response…" The Nursing IPN indicated the nurses made an independent decision to activate Emergency Medical Services (EMS) - 911, based on the seriousness of his injury, and signs and symptoms. The nurses' decision was prudent, given the significance of his signs and symptoms and his need for oxygen support. If the 8500-system for calling an emergency failed, if they have not already, Facility staff should revisit this emergency situation, and ensure processes are in place and functioning as they should.

c. A number of individuals were hospitalized for treatment of their acute illnesses. The acute illness/occurrence treated at the Facility for which licensed nursing staff conducted ongoing assessments was for Individual #494 – pharyngitis on 10/6/15.

d. Nursing staff conducted pre- and post-hospitalization assessments for Individual #147 – frequent cough and hypercapnia on 7/30/15, and right upper lobe pneumonia on 7/31/15; Individual #255 – hypoxia on 7/12/15; and Individual #481 – fall with laceration on 5/7/15.

e. In some cases, an acute care plan should have been developed, but was not. For those that were developed, plans were not in alignment with nursing protocols; did not include specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; did not define the clinical indicators nursing would measure; and/or lacked instructions regarding follow-up nursing assessments, including the frequency with which monitoring should occur.

The following provide some examples of concerns noted with regard to this outcome:

- For Individual #494, a PCP IPN, dated 9/9/15, noted receipt of a call that the individual needed to be sent out for nausea and vomiting, and no bowel movement in 30 days. Based on the documentation provided, the Monitoring Team could not determine the accuracy of the statement that the individual had not had a bowel movement in 30 days. However, given the blanks in the data and the lack of nursing staff's review of the data on a daily basis, the RN Case Manager should have identified a problem with documentation, at a minimum, and taken action to correct it. It is essential that nursing staff provide PCPs with accurate data.
- For Individual #588, the available Nursing IPNs for the period from 7/21/15 through 7/27/15 documented nine episodes of vomiting. The Nursing IPN, dated 7/27/15, documented vomiting 14 times for the month. Nursing IPNs dated 7/22/15, 7/23/15, and 7/25/15 documented decreased/no intake and output for shifts. He also received antiemetic suppositories for the vomiting. An acute plan should have been developed, but none was found.

- In some cases, acute care plans included handwritten notes, which were largely illegible and/or could not be interpreted with regard to when nurses needed to implement interventions.

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.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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.	44% 8/18	1/2	0/2	1/2	1/2	0/2	0/2	2/2	2/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #306 – skin integrity, and constipation/bowel obstruction; Individual #147 – gastrointestinal problems, and constipation/bowel obstruction; Individual #494 – gastrointestinal problems, and constipation/bowel obstruction; Individual #227 – constipation/bowel obstruction, and UTIs; Individual #521 – infections, and skin integrity; Individual #588 – gastrointestinal problems, and infections; Individual #255 – hypothermia, and infections; Individual #481 – constipation/bowel obstruction, and seizures; and Individual #532 – seizures, and constipation/bowel obstruction).

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

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #306 – constipation/bowel obstruction; Individual #494 – constipation/bowel obstruction; Individual #227 – UTIs; Individual #255 – hypothermia, and infections; Individual #481 – constipation/bowel obstruction, and seizures; and Individual #532 – seizures.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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.	11% 1/9	N/A	0/2	0/1	N/A	0/2	0/2	1/2	N/A	N/A
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).	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2

Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas.

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

b. The IDT for Individual #255 took immediate action related to infections. It was positive the IDT identified an action plan for minimizing his infections, such as respiratory infections. The steps included minimizing exposure to others, including individuals and staff who were ill; addressing environmental supports, such as using an air purifier, and employing universal precautions; and ensuring the individual and staff practiced an essential preventive measure against infections, that of hand hygiene.

c. Generally, for the individuals reviewed, documentation generally was not available to show their nursing interventions were implemented thoroughly. The exceptions were Individual #481's IHCP related to seizures for which seizure records appeared to be complete, and Individual #532 for seizures.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	Individual receives prescribed medications in accordance with applicable standards of care.	47% 8/17	1/2	1/2	1/2	1/2	1/2	0/1	1/2	1/2	1/2

b.	Medications that are not administered or the individual does not accept are explained.	56% 5/9	1/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
d.	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.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
e.	Individual's PNMP plan is followed during medication administration.	57% 4/7	0/1	1/1	0/1	1/1	N/A	N/A	0/1	1/1	1/1
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	0/1	1/1
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
h.	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.	22% 2/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
l.	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.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of eight individuals, including Individual #306, Individual #147, Individual #494, Individual #227, Individual #521, Individual #588 (deceased so no observation), Individual #255, Individual #481, and Individual #532.

a. and b. On a positive note, during observations, individuals received prescribed medications in accordance with applicable standards of care. However, for all individuals reviewed, Medication Administration Record (MAR) blanks were identified. In some cases, variance forms were completed, but in others they were not. In addition, circles on MARs indicating a missed medication were not consistently explained.

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

d. Nursing staff administered PRN medication, but at times, did not document the reason, route, and/or the individual's reaction or the effectiveness of the medication.

e. For some of the individuals with PNMPs that the Monitoring Team observed, nursing staff did not follow the PNMPs. The QA nurse who accompanied the Monitoring Team member intervened to correct the deficiencies, which was good to see.

f. For Individual #481, the nurse used non-sanitized/non-pre-packaged scissors from the nurse's uniform pocket to cut open the Omega3 capsule. The QA Nurse present for the observation indicated she planned to discuss the issue with Pharmacy Department staff to identify an improved and acceptable alternative(s) for piercing gel capsules.

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

h. When a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation was often not present to show individuals were monitored for possible adverse drug reactions.

k. Problems varied with regard to medications variances. Some of the problems included missing medication variance forms, forms that were in draft form and did not appear to have been completed, lack of investigation as to root cause, and lack of documented follow-up sufficient to address the underlying cause.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/13	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/2	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	15% 2/13	0/1	1/2	0/1	0/1	0/2	0/1	0/1	1/2	0/2

	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/13	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/2	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/13	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/2	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/13	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/2	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	43% 3/7	0/1	0/2	1/1	N/A	N/A	1/1	1/1	0/1	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1	0/2	0/1			0/1	0/1	0/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	29% 2/7	1/1	0/2	0/1			0/1	0/1	1/1	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/7	0/1	0/2	0/1			0/1	0/1	0/1	
	v. Individual has made progress on his/her goal/objective; and	0% 0/7	0/1	0/2	0/1			0/1	0/1	0/1	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1	0/2	0/1			0/1	0/1	0/1	

Comments: The Monitoring Team reviewed 13 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: choking for Individual #306; aspiration, and fractures for Individual #147; choking for Individual #494; choking for Individual #227; aspiration, and skin integrity for Individual #521; falls for Individual #588; fractures for Individual #255; falls, and weight for Individual #481; and weight, and choking for Individual #532.

a.i. and a.ii. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: fractures for Individual #147, and falls for Individual #481.

b.i. The Monitoring Team reviewed seven areas of need for six individuals that met criteria for PNMT involvement, including: falls for Individual #306; fractures, and aspiration for Individual #147; falls for Individual #494; aspiration for Individual #588; aspiration for Individual #255; and falls for Individual #481.

Individual #494, Individual #588, and Individual #255 were referred to the PNMT, but as discussed elsewhere in this report, none of them were referred in a timely manner. Other problems noted included:

- According to the most current OT/PT assessment submitted for Individual #306, dated 3/12/14, he had experienced 33 falls.

This represented an average of 2.75 falls per month, ranging from one to six (six occurring in June and November 2013). According to his IRRF, dated 3/31/15, he had experienced 23 falls in the previous year, with non-serious injuries reported. The IRRF indicated that most of these falls were related to seizures and an unsteady gait. From April 2014 to April 2015, he experienced 38 falls with four in the 30 days prior to PNMT referral. The IDT and/or PNMT provided no justification as to why a referral to the PNMT had not occurred before 4/16/15.

- The IDT for Individual #147 did not refer him to the PNMT for: 1) the fracture of his right hip in July 2015; or 2) frequent emesis, which increased his risk for aspiration.
- Individual #481's IDT should have referred him to the PNMT related to falls. His IRRF, dated 6/10/15, indicated that he would be referred to the PNMT, but there was no evidence of such a referral, despite a history of numerous falls with a serious injury on 5/7/15.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #306, and falls for Individual #481.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result of the lack of data and data analysis, 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.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/17	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/8	0/1	0/2	0/1	N/A	N/A	0/1	0/1	0/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/3	0/1	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A
Comments: a. As noted above, most IHCPs did not include all of the necessary PNM action steps to meet individuals' needs. In addition, the timeframes and/or criteria for the completion of actions steps were often vague (e.g., "ongoing"), and, as a result, there was no way											

to measure their completion.

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

- The IDT for Individual #147 did not refer him to the PNMT for: 1) the fracture of his right hip in July 2015, or 2) frequent emesis, which increased his risk for aspiration.
- The IDT did not refer Individual #306 to the PNMT in a timely manner despite increases in falls over a three-year period.
- For Individual #255, in addition to a lack of timely PNMT referral and review, PNMT follow-up was not sufficient to address the individual's needs. For example, on 11/13/15, a note indicated that the PNMT would conduct weekly follow-up due to "great concern" for Individual #255's status, yet the subsequent notes provided no evidence of weekly review.
- In August 2015, Individual #532's weight plateaued, and the October annual nutrition assessment noted that her diet was not resulting in gradual weight loss. Analysis indicated that overweight status likely was attributed to Olanzapine, which can contribute to weight gain and low activity level. No evidence was submitted of an ISPA meeting to address this concern, including, for example, development and implementation of an exercise program.

c. The following summarizes findings related to PNMT discharge:

- For Individual #306, no evidence was found of an ISPA meeting to review his discharge from the PNMT, which according to an IPN, occurred on 9/11/15.
- The PNMT had not conducted a comprehensive assessment for Individual #494, and, therefore, discharge was premature. An ISPA meeting was held to discuss findings of the PNMT review and discharge at the same time.
- On 7/1/15, the PNMT discharged Individual #588, although an ISPA did not reflect a discharge, but rather an IDT meeting. The last PNMT note indicated that they would meet in August to review data for emesis from July. There was no evidence that this occurred. The PNMT determined that emesis was due to Risperdal, but the IDT determined that the risk that his behavior posed was greater than the risk of vomiting, so the PNMT identified no further interventions. Documentation indicated that if he developed a "health decline" due to vomiting, the IDT should re-refer him to the PNMT. Individual #588 experienced a significant decline in health on 7/28/15 (i.e., aspiration pneumonia), and he died two days later with the cause of death listed as pneumonia.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	76% 66/87
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.	45% 5/11
Comments: a. The Monitoring Team conducted 87 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 33 out of 42 observations (79%). Staff followed individuals' dining plans during 31 out of 43 mealtime observations (72%). Transfers were completed according to the PNMPs in two of two observations (100%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: None											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
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	0/2	0/2	N/A	N/A	0/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/8	0/1	0/2	0/2			0/1	0/1	0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/8	0/1	0/2	0/2			0/1	0/1	0/1	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/8	0/1	0/2	0/2			0/1	0/1	0/1	
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/8	0/1	0/2	0/2			0/1	0/1	0/1	
Comments: a. and b. Individual #227, Individual #521, and Individual #532 had PNMPs to address PNM risks and needs, but based on documentation provided, none of them required other OT/PT supports and services (e.g., SAPs, direct therapy). Individual #147's OT/PT assessment included recommended goals/objectives, but no evidence was found that the IDT reviewed them and/or incorporated them into the ISP/ISPA action plans. Other individuals had OT/PT needs for which goals/objectives should have been considered, but there was no evidence of IDT discussion and/or justification for not addressing these areas of needs through direct therapy and/or SAPs (e.g., Individual #494 related to OT/PT direct services,, Individual #588 related to maintaining mobility, and Individual #481 related to falls and decline in functioning). In some cases, sufficient assessments had not been completed to determine										

the need for formal OT/PT supports (e.g., Individual #306, and Individual #255).

c. through e. Overall, largely due to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format and/or in a timely manner. As noted above, Individual #227, Individual #521, and Individual #532 did not require OT/PT supports beyond PNMPs. Individual #227 and Individual #521 were part of the outcome sample, so further review was not conducted. Individual #532 was part of the core sample, so a full review was conducted. Full reviews were conducted for the remaining six individuals.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	33% 1/3	N/A	1/1	0/2	N/R	N/R	N/A	N/A	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/1	N/A	0/1	N/A			N/A	N/A	N/A	N/A

Comments: a. As noted above, a number of individuals reviewed that should have had OT/PT services and supports included in their ISPs/ISPAs did not. However, for those supports that were identified, problems with their implementation included:

- For Individual #494, the assessment indicated that therapies were initiated on 10/6/15 for PT and 10/4/15 for OT. The plan was to provide him with direct OT and PT therapy three to five times a week. IPNs were submitted through 11/1/15. Based on this documentation, only one OT session, and one PT session occurred. A note, dated 11/30/15, indicated that nine OT sessions occurred during November 2015, providing further evidence that the therapy was not provided three to five times per week. Specifics about these sessions were not provided.

b. For Individual #147, documentation of implementation ended on 11/9/15, but no evidence was found for IDT approval for discharge from PT services.

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

			Individuals:								
#	Indicator	Overall Score	117	191	422	573	185	1	121	255	518
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 27/27	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	96% 26/27	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	70% 19/27	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		44	207	271	332	10	404	527	112	389
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		450	68	117	147	75	310	264	319	511
	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments: a. The Monitoring Team conducted observations of 27 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see.

b. The left brake did not work on Individual #117's walker.

c. Issues with proper fit of their wheelchairs were noted for eight individuals. Based on observation these individuals in their wheelchairs, the outcomes were that they were not positioned correctly. It is the Facility'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.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.

#	Indicator	Overall Score	147	313	306	2	227	532			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0/6 0%	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.	0/6 0%	0/6	0/6	0/6	0/5	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0/6 0%	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0/6 0%	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
4-7. As Lufkin SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators. Overall, personal goals were undefined, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.

#	Indicator	Overall Score	147	313	306	2	227	532			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	50% 3/6	1/1	0/1	0/1	0/1	1/1	1/1			
40	Action steps in the ISP were consistently implemented.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39-40. Documentation indicated that action steps were not regularly implemented, as noted in examples throughout this report. For the most part, observations and staff interviews indicated that staff were familiar with individual's ISPs and trained on supports, however, due to lack of consistent implementation, it was difficult to assess staff competency.

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.											
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
6	The individual is progressing on his/her SAPS	0% 0/24	0/3	0/2	0/2	0/3	0/3	0/2	0/3	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	100% 3/3	N/A	1/1	N/A	N/A	1/1	N/A	1/1	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/17	0/1	0/1	0/2	0/3	0/2	0/1	0/1	0/3	0/3
9	Decisions to continue, discontinue, or modify SAPs were data based.	19% 4/21	0/1	1/2	0/2	0/3	1/3	1/2	1/2	0/3	0/3

Comments:
6. None of the SAPs were rated as progressing. Some (e.g., Individual #7's clean room SAP) were not making progress. Some SAPs did not have sufficient data to determine progress and were scored as not making progress because they did not have reliable data (e.g., Individual #339's brush teeth SAP). Finally, some SAP data did indicate progress, but were scored as not making progress because they were not meaningful/functional (e.g., Individual #306's safely sit in the wheelchair) or did not have reliable data (e.g., Individual #88's bathing SAP).

7-9. Three SAP objectives were reported by the facility to be achieved (i.e., Individual #7's identify side effects of being over weight SAP, Individual #306's safety sit in his wheelchair SAP, and Individual #147's manipulate objects SAP) and all had a new objective established. On the other hand, 17 SAPs (e.g., Individual #339's apply lotion SAP) were judged by the facility as not progressing, however, there was no evidence that action was taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP) for any of them. Overall, there was evidence of data based decisions to continue, discontinue, or modify SAPs for 19% of SAPs (three SAPs had insufficient data to determine the use of data based decisions).

Outcome 4- All individuals have SAPs that contain the required components.											
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
13	The individual's SAPs are complete.	54% 13/24	2/3	1/2	2/2	1/3	2/3	1/2	1/3	2/3	1/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Fifty-four percent of SAPs were found to be complete. All SAPs, however, had the majority of these components. The most common missing component was the use of operational definitions of the target behavior. For example, Individual #147's bathing SAP did not specify what he needed to do to correctly bathe himself. Another common missing component was the absence of a task analysis. Many of the SAPs just contained one step (e.g., Individual #176's wash the wall SAP) suggesting that these either should be broken down into more steps to be most effective, or really represented compliance issues rather than the acquisition of new skills. Finally, some SAPs lacked specific instructions to teach the skill. For example, Individual #35's name his medications SAP indicated that least-to-most prompts should be used, however, it was not clear how one uses gestures or physical prompts when the target is a verbal behavior.

Outcome 5- SAPs are implemented with integrity.

#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
14	SAPs are implemented as written.	50% 2/4	0/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/24	0/3	0/2	0/2	0/3	0/3	0/2	0/3	0/3	0/3

Comments:
14. The Monitoring Team observed the implementation of four SAPs. Individual #88's exercise SAP and Individual #147's manipulate objects SAP were judged to be implemented and recorded as written. The DSP implementing Individual #176's wash jeans SAP, however, did not allow her sufficient time to independently complete each step by immediately moving to a verbal prompt. Similarly, the DSP implementing Individual #339's rub lotion SAP did not utilize the steps in the task analysis, or systematically apply the teaching prompts.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. Lufkin SSLC did conduct SAP integrity checks. However, the staff responsible for the SAP integrity checks indicated that they only observe a sample of SAPs. It is suggested that the facility establish a frequency goal of checking the integrity of each SAP at least once every six months, and establish a minimum level of acceptable integrity scores (e.g., 80%). Additionally, it is suggested that DSPs be immediately retrained and reassessed if they do not achieve the minimal acceptable integrity score.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.

#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
16	There is evidence that SAPs are reviewed monthly.	96%	2/3	2/2	2/2	3/3	3/3	2/2	3/3	3/3	3/3

		23/24									
17	SAP outcomes are graphed.	0% 0/24	0/3	0/2	0/2	0/3	0/3	0/2	0/3	0/3	0/3

Comments:
16. Ninety-six percent of the SAPs were reviewed monthly and that review included SAP data. Individual #339's walk with a guide SAP was not included in the monthly review.

17. The majority of SAP reviews included graphs of SAP outcomes (the exception was Individual #339's toothbrushing and applying lotion SAPs). The usefulness of the graphs, however, was limited because visual progress on the specific objective was not obvious (e.g., Individual #35's wash hair SAP).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
18	The individual is meaningfully engaged in residential and treatment sites.	44% 4/9	0/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
20	The day and treatment sites of the individual have goal engagement level scores.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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 four (Individual #7, Individual #88, Individual #35, Individual #313) of the nine individuals consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. At the time of onsite review, Lufkin SSLC was undergoing a reorganization of engagement, and they did not measure engagement in all residential and day programming sites, and there were no established engagement goals.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
#	Indicator	Overall Score	339	147	313	35	306	88	7	2	176
22	For the individual, goal frequencies of community recreational	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	activities are established and achieved.	0/9									
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 22-24. There was evidence that all nine of individuals participated in community outings, however, there were no established goals for this activity. Similarly, there was documentation that Individual #339, Individual #147, Individual #306, and Individual #7 had some SAP training in the community, however, there were no frequency goals established for this activity either. The facility should establish a goal frequency of community outings and SAP training in the community for each individual, and demonstrate that the goal was achieved.											

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
#	Indicator	Overall Score	313	35	7						
25	The student receives educational services that are integrated with the ISP.	100% 3/3	1/1	1/1	1/1						
Comments: 25. Individual #7, Individual #35, and Individual #313 were under 22 years of age and attended public school. All three students were receiving services from the local independent school. Additionally, the IDT worked with the school district to provide appropriate educational services. Finally, the ISP for each student included public school information and action plans that supported their IEPs.											

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.										
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/1								0/1	
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1								0/1	
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1								0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1								0/1	
Comments: Individual #481 had dental refusals, but no goal/objective to address them.											

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.											
#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/11	0/2	N/A	0/1	0/1	N/A	0/1	0/1	0/2	0/3
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/11	0/2		0/1	0/1		0/1	0/1	0/2	0/3
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/11	0/2		0/1	0/1		0/1	0/1	0/2	0/3
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/11	0/2		0/1	0/1		0/1	0/1	0/2	0/3
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/11	0/2		0/1	0/1		0/1	0/1	0/2	0/3
Comments: a. and b. At an ISPA meeting on 12/11/15, Individual #306's IDT discussed a communication assessment that included two goals/objectives, which the IDT approved. However, the team approved the Speech Language Pathologist's recommendation that the implementation of the direct therapy begin in the Spring of 2016. No clinical justification was provided for the delay in implementing direct therapy goals/objectives necessary to meet the individual's needs. Based on discussions with staff, it appeared that a decision had been made to catch up on long overdue assessments, and this was the reason for the delay. Although the communication assessments for Individual #481 and Individual #532 recommended goals/objectives related to communication, these individuals' ISPs did not include the recommended goals/objectives, and no rationale was provided for not including them.											

For Individual #147, his record included adequate justification for not currently pursuing formal communication supports (i.e., a documented effort to try different options, with consistent refusals). This is not to say that in the future additional trials might not be appropriate. Because he was part of the core sample, a full review was completed. For Individual #521, the communication assessment, dated 10/26/15, presented an appropriate plan of communication supports, although goal-directed therapy or SAPs were not indicated due to severity of communication and functional deficits. Because this individual was in the outcome group, further review was not conducted.

c. through e. For the remaining five individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.

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

#	Indicator	Overall Score	306	147	494	227	521	588	255	481	532
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/3	0/1	N/A	N/A	N/A	N/R	N/A	N/A	0/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	100% 1/1	N/A	N/A	N/A	N/A		N/A	N/A	N/A	1/1

Comments: a. As noted above, a number of individuals reviewed that should have had communication services and supports included in their ISPs/ISPAs did not. However, for those supports that were identified, problems with their implementation included:

- For Individual #306, direct therapy that should have been provided beginning in December 2015 was deferred until Spring 2016.
- No evidence was found to show that staff implemented the SAPs recommended for Individual #481.
- No evidence was found to show that staff implemented the SAP recommended for Individual #532.

b. With regard to termination of services and supports:

- For Individual #532, in August 2015, the IDT held an ISPA meeting to discontinue direct therapy and to initiate a SAP. The SLP wrote the ISPA IDT members signed it, presumably indicating their approval.

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.											
#	Indicator	Overall Score	129	241	68	117	298				
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	80% 4/5	0/1	1/1	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.	20% 1/5	0/1	1/1	0/1	0/1	0/1				
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	25% 1/4									
Comments: None.											

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) necessary to meet their appropriately identified needs, consistent with their informed choice.

Outcomes, indicators, and scores for this Domain will be included in the next Monitoring Team Report.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
- In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- In the past six months, individuals with dental emergencies;
- Individuals with Do Not Resuscitate Orders, including qualifying condition; and
- In the past six months, individuals with adverse drug reactions, including date of discovery.

- Lists of:
  - Crisis intervention restraints.
  - Medical restraints.
  - Protective devices.
  - Any injuries to individuals that occurred during restraint.
  - DFPS cases.
  - All serious injuries.
  - All injuries from individual-to-individual aggression.
  - All serious incidents other than ANE and serious injuries.
  - Non-serious Injury Investigations (NSIs).
  - Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
    - Were reviewed by external peer review
    - Were reviewed by internal peer review
    - Were under age 22
  - Individuals who receive psychiatry services and their medications, diagnoses, etc.

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

c. Medical
d. Nursing
e. Pharmacy
f. Dental

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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