United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

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Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

For a number of years now, Lufkin SSLC has been working on improving a variety of supports and services. Although staff's efforts resulted in some limited progress and increased stability, the need continues for intense focus in a number of areas where improvement in supports and services are necessary to protect the health and safety of the individuals Lufkin SSLC serves. This is particularly the case with regard to addressing conditions that place individuals at high risk, such as aspiration pneumonia and decubitus ulcers. Also impacting individuals' quality of life is the overall lack of meaningful engagement for many individuals.

As the Monitoring Teams discussed with the Facility Director, staff have taken a number of steps to address these issues, but, thus far, these actions have not resolved the underlying issues. Center staff need to work closely with State Office to identify the underlying issues or root causes on an individual and systemic level, and to review, revise, as appropriate, and submit to the Monitors an action plan for resolving these concerns. The measurement of the success of such a plan should be improved outcomes for individuals. The Monitors requested that the State submit to the Monitors and DOJ a plan that addressed, at a minimum, the following five topics. The State responded and provided a plan. The Monitors are reviewing the plan and will provide comments or questions over the weeks following submission of this report. The Monitors appreciated the State's responsiveness to this request.

1. **Aspiration Pneumonia Risk -** Since the January 2016 review, eleven individuals died. For six of these individuals, aspiration, aspiration pneumonia, and/or pneumonia were listed as causes of death. Based on infection control data, as well as a list of pneumonia events the Center provided to the Monitoring Team, the incidence of aspiration pneumonia was rising, with 25 episodes reported in Fiscal Year (FY) 2015; and 49 thus far in FY 2016, with data for August 2016 not yet available.
    a. Center staff reported that the pneumonia review process was not functioning properly. Based on the two reviews the Monitoring Team observed, the process lacked a robust discussion of the causal factors and failed to provide relevant clinical recommendations.
    b. As is detailed in this report, the Center was not providing individuals with the medical, nursing, or physical and nutritional supports they required. Individuals reviewed who had diagnoses of aspiration pneumonia included Individual #511 on 1/20/16 and 4/27/16, Individual #13 on 2/8/16, and Individual #240 on 5/31/16.
    c. It is essential that a physician is routinely available to participate with the Physical and Nutritional Management Team (PNMT) in its assessment and review processes, but this was not occurring consistently. An important role of the PNMT is to identify and develop supports to address the etiology or cause of the problem. For many of the individuals on the PNMT caseload, for example, those with aspiration pneumonia and/or decubitus ulcers, this can only occur with medical input and the engagement of the entire PNMT using a comprehensive, critical thinking model.
    d. As discussed in further detail below, Center staff were not identifying the root cause at either the individual or systemic level. For example, at the Quality Assurance/Quality Improvement (QA/QI) Committee meeting during the onsite review, staff presented root causes of aspiration pneumonia as emesis or secretion management, which would not be considered the root causes. To get at the actual causes, Center staff would need to continue to ask "why" until the underlying issue was revealed (e.g., the cause of the emesis, which might be, for example, untreated or less than optimally treated GERD; staff not properly trained on specific positioning or meal time strategies; staff not supervised to ensure implementation of specific positioning strategies; etc.).

2. **Decubitus Ulcers -** During this review and previous reviews, the Monitoring Team has continued to raise concerns about individuals with decubitus or pressure ulcers. Lufkin SSLC's data showed from February 2016 to October 1, 2016, a total of 15 individuals were identified with pressure ulcers. Of the 15, one ulcer was noted as unstageable, and was acquired at the hospital. For the remaining 14 individuals with pressure ulcers, the ulcers were acquired at the Center. Eleven of the Center decubitus were discovered at stage II, and two were discovered at stage III. Two of the 15 were not resolved. As has been recommended in the past, given that 80 individuals at Lufkin SSLC have feeding tubes as well as the continuing issues with pressure sores, consideration should be given to hiring a full-time certified Wound Ostomy Continence Nurse WOCN (RN) with specialized training in ostomies, wound, and continence care.

3. **Protection from Harm –** Critical components for eliminating abuse and neglect via strong incident management practices were below criteria at Lufkin SSLC. This was especially noteworthy given the progress most of the other Centers have made over the past few years. The Monitoring Team would like to see that actions are taken to ensure that incident management is conducted in a manner that meets criteria.

4. **Engagement –** More attention needed to be paid to providing individuals with interesting things to do on campus, in their homes and day programs, and in the community. Creating new opportunities for individuals, as well as teaching/supporting staff to engage individuals in

activities is receiving more attention from State Office, however, this direction from State Office has not yet arrived at Lufkin SSLC. Lufkin SSLC is especially ripe for new ideas, activities, and projects.

5. **Quality Assurance/Quality Improvement -** Quality assurance and root cause analysis were terms staff at Lufkin SSLC often used and in many different contexts. Although it was positive that staff were looking at what led to, or set the occasion for, incidents, injuries, allegations, illnesses, etc., the reviews often did not lead to identification of the true root cause or etiology of the negative outcomes. In addition, based on observation of the Center's QA/QI Committee meeting, Center staff were using incorrect or incomplete techniques for aggregating and/or analyzing data, and often were drawing incorrect conclusions from the available data. In turn, the incorrect conclusions stymied the Center's decision-making process related to next steps, or even the recognition that next steps were necessary. As the Lead Monitor discussed with the Facility Director during the onsite review, quality assurance is a professional field that has developed a variety of specific protocols and tools for data analytics, and conducting root cause analyses. State Office should provide the Center with training, technical assistance, and resources on the conduct of a root cause analysis, as well as data analytics.

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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.

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Eleven of these indicators, in restraint usage and incident management, had sustained high performance scores and will be moved to the category of requiring less oversight. This included two outcomes in abuse and neglect/incident management.

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

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

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

<u>Restraint</u>
Five indicators showed sustained high performance and were moved to the category of requiring less oversight, and many others showed good performance at this review. The frequency of crisis intervention restraints was among the highest when census-controlled-compared to the other facilities. That being said, there was a descending trend across the previous nine months, due in large part, to a decrease in the frequency of restraints of one individual. Along the same lines, the facility had the highest average duration of a physical restraint, two or three times the duration of most other facilities, that is, around 12 minutes. The average duration, however, was lower than the last two reviews and showed a decreasing trend over the past nine months. Restraint review practices, for the most part, were timely and thorough, and typically resulted in multiple follow-up planned actions. There was an active restraint reduction committee.

For the restraints reviewed, nursing staff usually initiated monitoring timely. However, some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring and documenting individuals' respirations, even when they refuse other vital signs; reassessing individuals with abnormal vital signs; monitoring individuals for potential side effects of chemical restraints; providing more detailed descriptions of individuals' mental status, including specific comparisons to the

individual's baseline; conducting and documenting skin integrity assessments for physical restraints; and documenting details and follow-up for restraint-related injuries. These indicators will remain in active monitoring.

Abuse, Neglect, and Incident Management

Though six indicators moved to the category of requiring less oversight, continued focus upon investigation practices is needed. For instance, there were three cases of apparent late reporting, all of the facility-only investigations were lacking one or more of the required elements for a complete and thorough investigation, and UIRs contained very little data explaining who was interviewed and the subject matter of interviews. Furthermore, DFPS recommendations were not carried forward to UIR recommendations, and the supervisory review process of investigations needed to pay better attention to detail.

Other

Some IDTs were talking about the pretreatment chemical restraint needs of individuals. Overall, PTCR practices needed more focus in order to meet the outcomes and indicators evaluated by the Monitoring Teams.

Quality assurance and root cause analysis were terms used often at Lufkin SSLC and in many different contexts. It was good to see facility management wanting to understand what led to, or set the occasion for, incidents, injuries, allegations, illnesses, etc. Quality assurance is a professional field and, as such, the field has developed a variety of specific protocols and tools for conducting root cause analyses. The Monitoring Team recommends that management seek guidance, perhaps from state office, as to the conduct of a root cause analysis that will take them beyond their current procedures.

From January 2016 to October 2016, the Center completed only two clinically relevant Drug Utilization Evaluations (DUEs). In January 2016, a follow-up DUE related to Dilantin use resulted in only a single-page graph with no narrative. DUEs should consistently include findings. Moreover, the Center did not provide any evidence of action plans associated with any of the DUEs completed. Recommendations should be generated, as appropriate, and followed through to closure.

Self-advocacy activities have a variety of benefits, one of which is protection from harm. The human rights officer was new to his position. One priority area is to get self-advocacy committee going again. Perhaps starting small will increase the likelihood of success, such as beginning with one unit or perhaps even one or two homes and expanding from there.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.	
Summary: Lufkin SSLC attended to restraint usage and management by reviewing data, conducting restraint review committee, and implementing actions to reduce the frequency and duration of various types of restraint. Progress was evident, though more work was needed. Both indicators showed improvement since the last	Individuals:

review and both will remain in active monitoring.											
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	58% 7/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	64% 7/11	0/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past eight months (February 2016 through September 2016) were reviewed. Due to the changeover to the electronic record (called IRIS), state office was unable to provide these data and graphs. Instead, the facility provided the data and graphs for an eight-month period. The Monitoring Team calculated the 1000-bed-day number using the facility-provided average daily census

The frequency of crisis intervention restraints at Lufkin SSLC was among the highest when census-controlled-compared to the other facilities, that is, only two facilities were higher, Mexia SSLC and San Angelo SSLC. That being said, there was a descending trend across the previous nine months, due in large part, to decrease in the frequency of restraints of Individual #410. As a result, that set of data was scored as meeting criterion for this indicator. This was also the case for the frequency of crisis intervention physical restraints. Along the same lines, Lufkin SSLC had the highest average duration of a physical restraint, two or three times the duration of most other facilities, that is, around 12 minutes. The good news was that the average duration was lower than the last two reviews and also showed a decreasing trend over the past nine months. The facility should continue, as they have been, to focus on this. The Monitoring Team's scoring of these three data sets as meeting criterion does not mean that continued work is not necessary to address frequency and duration. The frequency of crisis intervention chemical restraints was low, but showed an ascending trend, thereby not meeting criterion. There were zero occurrences of crisis intervention mechanical restraint. Individual #410 accounted for a majority of the crisis intervention restraints at the facility over the past few years. Over the past nine months, much progress and improvement had occurred. Everyone at the facility was proud of this accomplishment.

The number of injuries that occurred during restraint was ascending, and the number of individuals who had any crisis intervention restraint remained relatively high, though stable. Usage of protective mechanical restraint for self-injurious behavior (PMR-SIB) remained low, at one individual, and usage for him was decreasing.

There were no occurrences of non-chemical restraint for medical or dental procedures. There were no data on the use of chemical restraint for medical or dental procedures, therefore, those two data sets were scored as not meeting criterion.

The facility had an active restraint reduction committee. Restraint reduction and restraint management were long a focus of the facility's and of the behavioral health services director. This has included a reduction of the number of individuals with PMR-SIB. Further, for the five individuals who had a protective device that did not meet the PMR-SIB definition, the behavioral health services department ensured that proper assessment, rationale, management, fading, and review by BSC, HRC, and IDT occurred.

Thus, state and facility data showed low usage and/or decreases in seven of these 12 facility-wide measures (i.e., use of crisis intervention restraint, use of crisis intervention physical and mechanical restraint, the duration of physical restraints, the number of individuals with PMR-SIB, and the use of non-chemical restraints for medical and dental procedures).

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, the Monitoring Team reviewed restraint incidents for two additional individuals (Individual #410, Individual #176) for a total of seven individuals. Six received crisis intervention physical restraints (Individual #65, Individual #145, Individual #401, Individual #259, Individual #3, Individual #410) and two received crisis intervention chemical restraints (Individual #145, Individual #176). Data from the facility showed a decreasing trend in frequency or very low occurrences over the past eight months for three (Individual #259, Individual #410, Individual #176). The other four individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

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

Summary: Overall, Lufkin SSLC implemented restraint according to criteria for about half of the indicators this outcome. In particular, four indicators (3, 4, 6, and 8) had high scores for this review and the last two reviews. These four indicators will be moved to the category of requiring less oversight. Indicators 5 and 10 might move to the category of requiring less oversight with sustained high performance, after the next review. Two indicators (7 and 11) can likely be corrected and improved. Indicator 9 will require attention and documentation, perhaps including some additions to the restraint checklist or an addendum. These five indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	65	145	401	259	3	410	176		
3	There was no evidence of prone restraint used.	100% 11/11	2/2	2/2	1/1	2/2	2/2	1/1	1/1		
4	The restraint was a method approved in facility policy.	100% 11/11	2/2	2/2	1/1	2/2	2/2	1/1	1/1		
5	The individual posed an immediate and serious risk of harm to him/herself or others.	91% 10/11	2/2	2/2	1/1	2/2	1/2	1/1	1/1		
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 8/8	2/2	1/1	1/1	2/2	1/1	1/1	N/A		
7	There was no injury to the individual as a result of implementation of the restraint.	73% 8/11	1/2	1/2	1/1	2/2	1/2	1/1	1/1		
8	There was no evidence that the restraint was used for punishment or	100%	2/2	2/2	1/1	2/2	2/2	1/1	1/1		

	for the convenience of staff.	11/11									
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/7	0/2	0/2	0/1	Not rated	0/2	Not rated	Not rated		
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	91% 10/11	2/2	1/2	1/1	2/2	2/2	1/1	1/1		
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	73% 8/11	2/2	2/2	0/1	0/2	2/2	1/1	1/1		

Comments:
The Monitoring Team chose to review 11 restraint incidents that occurred for seven different individuals (Individual #65, Individual #145, Individual #401, Individual #259, Individual #3, Individual #410, Individual #176). Of these, nine were crisis intervention physical restraints, and two were crisis intervention chemical restraints. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

5. For Individual #3 7/29/16, the restraint checklist stated he was aggressive to staff. More specificity as to what made this an immediate and serious risk of harm was needed to meet criterion. Supplemental documentation submitted by the facility did not address this.

6. There was some confusion regarding the duration of the crisis intervention physical restraint for Individual #410 7/14/16. The restraint checklist presented it as a 62 minute restraint, but behavioral health services data and the tier 1 document request presented it as two separate restraints that occurred within the 62 minute period (i.e., the correct way to present this. This was discussed onsite with the behavioral health services director.

7. Two restraints (Individual #65 6/16/16, Individual #145 3/12/16) did not meet criterion because there was conflicting information on the restraint checklists versus the face to face assessment and debriefing forms. Individual #3 7/17/16 had a non-serious injury (a scratch).

9. Because criterion for indicator #2 was met for three of the seven individuals, this indicator was not scored for them. For the other four, criteria for this indicator were not met because of absence of engagement in functional programming as per observation and monthly reviews (Individual #145, Individual #401, Individual #3), medical issues related to behavior, such as gastro-intestinal problems were not ruled out (Individual #401), environmental considerations were not evaluated, such as roommates and home lifestyle (Individual #145), and absence of data to support implementation of the ISP, especially in a manner likely to be effective while at school (Individual #65).

10. For Individual #145 3/12/16, criteria were not met because there was no indication that staff used the least restrictive restraint first. This was recognized by the facility and staff were retrained.

11. For three of the individuals, the IRRF section of the ISP was not correctly completed regarding considerations in the use of crisis intervention restraint. This important information needs to be included.

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

Summary: Staff answered most questions correctly, however, staff for two individuals could not identify prone restraint as a prohibited method of physical restraint until they were provided with lots of leading questions. Additional training should occur. The 60% score for this indicator was the same score as the last two times, too. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	65	145	401	259	3	410	176		
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	60% 3/5	0/1	1/1	1/1	1/1	0/1	Not rated	Not rated		

Comments:
12. Because criteria for indicators 2-11 were met for Individual #410 and Individual #176, this indicator was not scored for them.

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.

Summary: Four of 10 restraints did not have proper restraint monitor activity. The percentage of restraints that met criteria for this indicator had declined over this and the previous two reviews. This is an area of focus for the facility. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	65	145	401	259	3	410	176		
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	64% 7/11	1/2	2/2	1/1	0/2	2/2	1/1	0/1		
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		

Comments:
13. Four restraints did not meet criteria because a restraint monitor was not present within the 15 minute time requirement from the initiation of the restraint.

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

Summary: For the restraints reviewed, nursing staff usually initiated monitoring timely. However, some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring and documenting individuals' respirations, even when they refuse other vital signs; reassessing individuals with abnormal vital signs; monitoring individuals for potential side effects of chemical restraints; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; conducting and documenting skin integrity assessments for physical restraints; and documenting details and follow-up for restraint-related injuries. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 65	145	401	259	3	410	176		
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	0% 0/11	0/2	0/2	0/1	0/2	0/2	0/1	0/1		
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	0% 0/11	0/2	0/2	0/1	0/2	0/2	0/1	0/1		
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/11	0/2	0/2	0/1	0/2	0/2	0/1	0/1		

Comments: The crisis intervention restraints reviewed included those for: Individual #65 on 5/13/16 at 8:25 p.m., and 6/16/16 at 2:25 p.m.; Individual #145 on 3/12/16 at 3:40 a.m. (chemical), and 7/31/16 at 1:48 p.m.; Individual #401 on 2/1/16 at 3:55 p.m.; Individual #259 on 3/4/16 at 1:55 p.m., and 5/5/16 at 10:00 a.m.; Individual #3 on 7/17/16 at 10:35 p.m., and 7/29/16 at 11:21 a.m.; Individual #410 on 7/14/16 at 3:05 p.m., and Individual #176 on 4/4/16 at 9:05 a.m. (chemical).

a. For nine of the 11 restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #145 on 7/31/16 at 1:48 p.m. (i.e., the form contained blanks for arrival and departure times), and Individual #259 on 3/4/16 at 1:55 p.m. (i.e., the form noted the nurse was not notified until seven days after the restraint).

For five of the 11 restraints, nursing staff monitored and documented vital signs according to applicable standards. This included the restraints for Individual #65 on 6/16/16 at 2:25 p.m., Individual #401 on 2/1/16 at 3:55 p.m., Individual #259 on 5/5/16 at 10:00 a.m., Individual #3 on 7/29/16 at 11:21 a.m., and Individual #410 on 7/14/16 at 3:05 p.m. Some of the problems noted with other restraints included:

- For chemical restraints, Individual #145 and Individual #176 received Ativan intramuscular (IM), which has the potential to cause orthostatic hypotension, but nursing staff did not document observations for potential medication side effects;
- Notes that stated: "refused," but did not include respirations, which do not require the individual's cooperation;
- Findings that should have resulted in reassessment, but the nurse did not complete or document reassessment results (e.g.,

Individual #145 with a heart rate of 100, and Individual #176 with a tacky pulse of 108, and slightly elevated blood pressure with no indication of comparison to the individual's baseline blood pressure);
- Blanks on restraint forms for vital signs, and/or no corresponding IPNs; and a
- As noted above, nursing staff not being notified timely of a restraint.

In none of the instances did the nurse provide a sufficient description of the individual's mental status (e.g., often the only description was "alert and oriented").

b. and c. Examples of problems included:
- Nursing IPNs did not include necessary assessments, such as skin integrity assessments for physical restraints.
- For Individual #65's restraint on 6/16/16, the injury report noted: "scratch to stomach and two red spots to the back of his head." A corresponding nursing IPN, dated 6/16/16 at 3:30 p.m., did not provide details (i.e., length, width, or size) of the skin integrity issues noted on the Incident Report.
- Sometimes, it was difficult to determine from the documentation whether or not a noted injury occurred during the restraint, or if there was another explanation for the injury.
- For Individual #3, a nursing IPN, dated 7/17/16 at 11:40 a.m., denoted skin integrity issue and "c/o [complaints of] mild pain to face." However, no documentation was found to show nursing staff further evaluated the individual for pain and/or for consideration for pain medication.
- As noted above, Individual #176 had a tacky pulse of 108, and slightly elevated blood pressure with no indication of what the individual's blood pressure is regularly, but nursing staff documented no follow-up.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

Summary: Nursing/injury related information needs to be included in the restraint checklist. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	65	145	401	259	3	410	176		
15	Restraint was documented in compliance with Appendix A.	82% 9/11	2/2	1/2	1/1	2/2	2/2	1/1	0/1		

Comments:
15. For Individual #145 3/12/16, a nurse was not listed as to who was involved in the restraint. Presumably a nurse administered the chemical restraint. Also, the restraint checklist did not document whether or not an injury occurred related to this restraint. For Individual #176 4/4/16, the required nursing entries were not on the restraint checklist, but need to be.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.

Summary: With continued improvement and sustained performance, these indicators might move to the category of requiring less oversight after the next review.

Individuals:

#	Indicator	Overall Score	65	145	401	259	3	410	176		
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	91% 10/11	2/2	2/2	1/1	1/2	2/2	1/1	1/1		
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	91% 10/11	2/2	1/2	1/1	2/2	2/2	1/1	1/1		

Comments:
16. For Individual #259 3/4/16, the restraint occurred on 3/4/16 but was reported on 3/11/16 because staff forgot to report, thus it was a late review.

17. For Individual #145 3/12/16, the facility provided documentation (an ISPA), but it wasn't for this restraint.

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)

Summary: Indicator 48 met criteria for this review and the two previous reviews and will be moved to the category of requiring less oversight. With sustained performance, indicator 47 might also be moved to this category after the next review. Documentation of follow-up following chemical restraint, indicator 49, will require some focus from the psychiatry department. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	145	176							
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 2/2	1/1	1/1							
48	Multiple medications were not used during chemical restraint.	100% 2/2	1/1	1/1							
49	Psychiatry follow-up occurred following chemical restraint.	0% 0/1	0/1	N/A							

Comments:
47-49. These indicators applied to chemical restraints for Individual #145 and Individual #176. For Individual #145, she was not seen for follow-up until her next already scheduled clinic appointment, which was eight weeks later (though at the time of this onsite review, she was being seen every week). The Monitoring Team did not have enough information to determine if Individual #176 was seen for follow-up after the chemical restraint.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Overall, good progress was made in addressing the requirements of this outcome and its indicator, especially regarding the completion of duty to report forms. Ongoing focus on the components of this indicator should result in continued progress. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	145	259	3	210	2				
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	70% 7/10	1/2	1/3	2/2	2/2	1/1				

Comments:

The Monitoring Team reviewed 10 investigations that occurred for five individuals. Of these 10 investigations, five were DFPS investigations of abuse-neglect allegations (two confirmed, two unconfirmed, one administrative referral back to the facility). The other five were for facility investigations of serious injuries, unauthorized departure from the facility, suicide threat, and sexual behavior related incidents. 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 #145, UIR 247, DFPS 44515549, administrative referral for an allegation of neglect, 7/6/16
- Individual #145, UIR 271, injury to head/scalp, 7/28/16
- Individual #259, UIR 178, DFPS 44298432, unconfirmed allegation of neglect, 4/6/16
- Individual #259, UIR 144, suicide threat, 3/1/16
- Individual #259, UIR 146, unauthorized departure, 3/4/16
- Individual #3, UIR 230, DFPS 44430584, inconclusive, unconfirmed, and confirmed allegations of physical abuse, 6/17/16
- Individual #3, UIR 257, sexual Incident, possession of contraband, 7/17/16
- Individual #210, UIR 179, DFPS 44297071, unconfirmed allegation of neglect, 4/8/16
- Individual #210, UIR 265, injury to eye, 7/21/16
- Individual #2, UIR 251, DFPS 44512644, confirmed allegation of physical abuse 2, 7/10/16

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

Seven investigations met all criteria for this indicator. Some details regarding the above four aspects of this indicator are as follows:

- a. Staff criminal background checks and signing of duty to report forms were in place for all individuals for all 10

investigations. This was a very good improvement from the previous review.

- b. For eight of the 10 investigations, there was evidence that the facility had reviewed trends of behaviors related to five of the eight incident investigations (e.g., peer to peer aggression Individual #145 UIR 247, injuries Individual #145 UIR 271, behavior problems already in the PBSP Individual #3 UIR 230 and Individual #3 UIR 257, vision Individual #210 UIR 265). For the other three, trends were not expected to have been reviewed because the behavior related to the incident first occurred during this incident or it was an isolated incident, so there was no history (Individual #259 UIR 146, Individual #210 UIR 179) or the allegation was regarding staff behavior not related to any individual behavior that had a history or trend (Individual #2 UIR 251).
    - Two investigations did not meet criterion. For Individual #259 UIR 178, each of the four individuals involved in this case had a PBSP. The UIR relevant history section cited past incidents, but there is no analysis related to these four individuals and aggression/interactions they've had in the past. Nor was there a review of the efficacy of each individual's PBSP. For Individual #259 UIR 144, suicide threat was not included in his PBSP data review.
- c and d. Plans were in place and were revised as necessary to address any identified risk or identified trend for six of the seven investigations to which this applied (i.e., it applied to all but Individual #259 UIR 146, Individual #210 UIR 179, Individual #2 UIR 251). Examples included evidence of PBSP implementation (Individual #3 UIR 230 and Individual #3 UIR 257) and vision assessment with staff training (Individual #210 UIR 265).
    - Individual #145 UIR 271 did not meet criterion because the plan was to continue with three actions that had not been effective.

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

Summary: Some incidents were not reported correctly. Performance remained about the same as during the last review. The facility should ensure that any inconsistencies in reporting information is cleared up and clarified in the UIR. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	145	259	3	210	2				
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	70% 7/10	1/2	2/3	2/2	1/2	1/1				

Comments:

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

Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them. A good incident management system needs to analyze whether or not reporting occurred within facility/state policy (and Settlement Agreement) requirements and document this analysis (and conclusions) in the body of the UIR.

- Individual #145 UIR 247: The UIR showed that the incident occurred on 7/6/16 at 8:36 pm and was reported to the facility director/designee on 7/7/16 at 1:29 am. There was no explanation in UIR for the delay.
- Individual #259 UIR 178: The DFPS report and UIR noted that the incident occurred on 4/6/16 and was reported on 4/9/16. The UIR should have attempted to reconcile this. When data shows an incident is reported late, the facility, in the UIR, should provide an explanation (actual data or a likely hypothesis) as to the circumstances. In this case, if the report was, for example, made by DADS Guardianship, it would not be considered a late report.
- Individual #210 UIR 179: The DFPS report and UIR showed that the incident occurred at 8:50 am. The DFPS report showed they received the intake at 9:57 am. The UIR showed facility director/designee notification at 10:54 am. The UIR did not provide any explanation for this apparent lack of timely reporting.

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

Summary: Lufkin SSLC maintained good performance across this review and the last two reviews. Therefore, indicator 5 will move to the category of requiring less oversight. Indicator 3 will remain in active oversight, in part, due to the need for improvement in reporting. With improvement in the posters being posted, indicator 4 might move to the category of requiring less oversight after the next review.

Individuals:

#	Indicator	Overall Score	145	259	3	210	2				
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 2/2	1/1	1/1	Not rated	Not rated	Not rated				
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	80% 8/10	0/2	3/3	2/2	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% 10/10	2/2	3/3	2/2	2/2	1/1				

Comments:

3. Because indicator #1 was met for three of the individuals, this indicator was not scored for them. The indicator was scored for the other two individuals and criteria were met.

4. The reporting poster was not in Individual #145's home. After this was reported by the Monitoring Team to the facility, it was corrected.

5. There were no occurrences of expressions of concerns of retaliation.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
Summary: With sustained high performance, this indicator might move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	145	259	3	210	2				
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 10/10	2/2	3/3	2/2	2/2	1/1				
Comments:											

Outcome 5– Staff cooperate with investigations.											
Summary: The facility met criteria for 100% of the investigations during this and also during the previous two reviews. Therefore, this indicator will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	145	259	3	210	2				
7	Facility staff cooperated with the investigation.	100% 10/10	2/2	3/3	2/2	2/2	1/1				
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: All staff identified as involved in an investigation need to be interviewed (or a rationale provided as to why not), and details of the interview need to be included in the UIR investigation. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	145	259	3	210	2				
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	40% 4/10	0/2	1/3	1/2	1/2	1/1				
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	40% 4/10	0/2	1/3	1/2	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)	100% 10/10	2/2	3/3	2/2	2/2	1/1				

Comments:
8-9. Six investigations did not meet criteria because the UIRs listed staff who were involved, but did not provide any evidence that any of them were interviewed, nor any explanation as to why interviews were not done. Further, for staff who were interviewed, the UIR did not show any detail of the content of the interview.

10. Despite the absence of staff interviews that could have added insight as to the circumstances leading up to the event, video evidence was sufficient to support the conclusion for some of the investigations. For others, the UIR contained a running chronology that provided enough evidence, along with some statements attributed to some staff, to draw a reasonable conclusion.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: Investigations are, and have been commenced within 24 hours and completed within 10 calendar days (with one exception being completed in 11 days) for this review and the last two reviews. Therefore, indicators 11 and 12 will move to the category of requiring less oversight. Indicator 13 requires more focus and it will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	145	259	3	210	2				
11	Commenced within 24 hours of being reported.	100% 10/10	2/2	3/3	2/2	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).	90% 9/10	2/2	3/3	2/2	2/2	0/1				
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	0% 0/10	0/2	0/3	0/2	0/2	0/1				

Comments:
12. Individual #2 UIR 251 was completed one day past the required 10 days, with no extension.

13. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.											
Summary: Lufkin SSLC showed 100% performance on these indicators during this review and the last review. Given this sustained performance, and given a good system, these two indicators will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	145	259	3	210	2				
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 5/5	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% 5/5	1/1	1/1	1/1	1/1	1/1				
Comments:											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: Performance on these indicators has wavered over this and the last two reviews. Greater focus and attention to the requirements of these indicators may result in improved scores (and improved supports). These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	145	259	3	210	2				
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	70% 7/10	2/2	2/3	1/2	2/2	0/1				
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	50% 2/4	N/A	1/1	0/1	1/1	0/1				
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	80% 8/10	2/2	3/3	1/2	2/2	0/1				
Comments: 16. Three investigations did not meet criteria for this indicator: Individual #259 UIR 178 did not have any recommendations for behavior review, but should have. For Individual #3 UIR 230, the DFPS investigation listed six specific recommendations. Only one was carried over to the UIR, which had three recommendations. For Individual #2 UIR 251, DFPS noted three recommendations. These did not directly transfer to the UIR recommendations. 17-18. For Individual #3 UIR 230, evidence was not provided as to whether recommendations actions were taken. For Individual #2											

UIR 251, only the first page of the pre-disciplinary letter was provided; the Monitoring Team could not determine what the planned/actual action was. In addition, the recommendations conveyed in the DFPS report were not addressed.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. Lufkin SSLC collected data and completed the required trend reports. More work, that is, quality assurance protocols are needed to meet indicators 21, 22, and 23. Assistance from state office is likely needed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	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. To reiterate from the last report: 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.											

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental	N/A									

	treatment, proper procedures are followed.										

Comments: a. The Dental Procedures Manual, revised 4/7/15, documented the process utilized prior to the use of TIVA. It noted that TIVA was recommended for assessments, and treatment for complex procedures such as endodontic therapy, tooth extraction, placement of crowns, and deep scaling of teeth. The names of individuals being considered for TIVA were submitted to the dental anesthesiologist who determined whether the use of on-campus TIVA was appropriate. If approved, the dentist submitted a consultation form for review by pharmacy, psychiatry, and the PCP. The clinicians reached a consensus opinion regarding the use of proposed medications. The opinion was forwarded to the IDT for review and approval. The desensitization processes, as well as the use of strategies to minimize the need for pre-treatment chemical restraints (PTS) were also outlined in the procedures manual.

Records documented that the PCPs completed a pre-TIVA assessment; however, forms often had blank sections. The Medical Department submitted policies related to integration of clinical services. No medical policy was submitted that detailed the requirements of the perioperative assessments.

The Center utilized a template for all dental procedures. However, the dentist's notes did not include the vital information typically seen, such as: preoperative diagnosis, postoperative diagnosis, procedures performed, and description of procedure. The description of the procedure typically notes that informed consent was obtained in addition to the condition of the individual prior to the procedure, the type of anesthesia that is being utilized, a description of the procedure, and the condition of the individual after the procedure.

For these two instances of use of TIVA, nothing-by-mouth status was confirmed, and post-operative vital sign flow sheets were submitted. Informed consent was confirmed for Individual #592.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess this indicator.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/3	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A	0/1

Comments: For all three of the instances reviewed of oral pre-treatment sedation for medical treatment, pre-procedure vital signs were documented, which was good to see. However, for Individual #511, post-procedure vital signs were not documented for the sedation on 4/26/16. More specifically, on 4/26/16 at 11:15 a.m., Individual #511 was administered Ativan 4 milligrams (mg) by mouth (PO). The IPNs during this time appeared incomplete. There were no entries from 4/20/16 to 4/26/16. On 4/27/16, this individual was transferred to the Emergency Department (ED) and admitted to Intensive Care Unit (ICU) with hypoxia and pneumonia. The events surrounding the transfer were not clear.

In addition, the Center did not provide evidence of input from an interdisciplinary committee/group, or informed consent for any of

these uses of pre-treatment sedation.

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.

Summary: For two individuals, actions were taken as required by this outcome, including a determination that PTCR would be counter-therapeutic. For the other two individuals, the required actions were not taken, so in addition, a determination could not be made as to whether action plans should have been developed. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 145	222	97	210					
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	50% 2/4	1/1	0/1	1/1	0/1					
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	50% 2/4	1/1	0/1	1/1	0/1					
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A	N/A	N/A	N/A	N/A					
4	Action plans were implemented.	N/A	N/A	N/A	N/A	N/A					
5	If implemented, progress was monitored.	N/A	N/A	N/A	N/A	N/A					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A	N/A					

Comments:

1-6. This outcome and its indicators applied to Individual #145, Individual #97, Individual #222, and Individual #210. Individual #145 had TIVA on 3/6/16 for dental deep cleaning. Individual #97 was administered Ativan in April 2016 prior to an allergist's appointment. Individual #222 had TIVA on 6/7/16 for the treatment of an abscess. Individual #210 had pretreatment chemical restraint on 7/1/16 prior to an ophthalmologist appoint.

1. There was evidence that Individual #145 and Individual #97's IDTs identified the need for PTCR and supports necessary. Individual #222's IDT discussed past PTCR usage and effectiveness, and obtained consent from the LAR/Facility Director. There was not evidence, however, of a discussion the behaviors observed that warranted the use of PTCR, the use of additional supports or interventions that

could be provided for future appointments, or evidence of a discussion of the risk and benefit of the procedure without PTCR versus with PTCR. There was no evidence that Individual #210's IDT reviewed his pretreatment sedation.

2. Individual #145 and Individual #97's IDTs determined that any actions to reduce PTCR would be counter-therapeutic. There was no evidence that Individual #222's or Individual #210's IDTs reviewed his pretreatment chemical restraint.

3-6. There were no treatments or strategies developed to minimize the need for PTCR for any of the individuals. Because Individual #222 and Individual #210's IDTs did not take the actions as required by this indicator, it could not be determined if actions should have been taken.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.

Summary: The Monitoring Team will continue to assess these indicators.

#	Indicator	Overall Score	Individuals: 520	444	366	521	556	535	527	424	298	240	142
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% 11/11	1/1	1/1	1/1	1/1	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.	0% 0/11	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/11	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/11	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Recommendations are followed through to closure.	0% 0/11	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. Since the last review, 11 individuals died. The Monitoring Team reviewed all 11 deaths. Causes of death were listed as:

- On 1/2/16, Individual #520 died at the age of 51 with causes of death listed as respiratory failure, acute kidney failure, and congestive heart failure;

- On 1/5/16, Individual #444 died at the age of 81 with the cause of death listed as end stage renal disease;
- On 1/9/16, Individual #366 died at the age of 74 with causes of death listed as respiratory failure, bilateral pneumonia, and atrial fibrillation;
- On 2/1/16, Individual #521 died at the age of 42 with causes of death listed as acute chronic respiratory failure, bowel obstruction, Dandy Walker Syndrome, and recurrent aspiration;
- On 2/17/16, Individual #556 died at the age of 75 with causes of death listed as severe sepsis with septic shock, respiratory failure, and aspiration pneumonia;
- On 3/7/16, Individual #535 died at the age of 47 with causes of death listed as respiratory failure, bilateral pneumonia, septic shock, and anasarca;
- On 5/21/16, Individual #527 died at the age of 53 with cause of death listed as respiratory failure;
- On 5/24/16, Individual #424 died at the age of 57 with causes of death listed as chronic obstructive pulmonary disease (COPD), and chronic respiratory failure;
- On 6/19/16, Individual #298 at the age of 54 died with causes of death listed as cardiac arrest, cardiac arrhythmia, and renal insufficiency;
- On 7/15/16, Individual #240 died at the age of 62 with causes of death listed as septic shock, right lower lobe pneumonia, aspiration, and rectal bleeding requiring blood; and
- On 9/18/16, Individual #142 died at the age of 62 with causes of death listed as vomiting, aspiration, respiratory failure, and dysphagia.

b. through d. Some of the concerns with regard to recommendations included:

- Evidence was not submitted to show the Center conducted thorough reviews of medical care. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.
- For a number of important findings in the Quality Assurance Death Reviews, corresponding recommendations were not made. In other instances, the Quality Assurance Death Reviews contained recommendations, but then they were not included in the Administrative or Clinical Death Reviews, and no justification was provided for not including them. A few of many examples included:
    - The Quality Assurance Death Review for Individual #535 included the following finding: "Increased seizure activity was recognized by nursing staff but was not communicated to the PCP for review." Unfortunately, none of the 13 significant findings were included as formal recommendations or actions steps for improvement.
    - Individual #366's Quality Assurance Death Review included eight findings, including the following: "No mention of metastatic cancer found in the IHCP or IRRF… No ACP [acute care plan] completed in regards to the metastatic cancer pain she experienced during her last week on the LfSSLC Campus." These findings were not addressed through recommendations.
    - For Individual #424, the Quality Assurance Death Review identified eight findings. There was follow-through on one of the eight findings in the Administrative Death Review. One example of an important finding that did not result in formal recommendation/action step read: "No ISPAs were found addressing her vomiting episodes."
    - Individual #240's Quality Assurance Death Review identified 16 findings. Under Recommendations, it stated: "TBD [to be determined] upon clinical death review committee's review of the above findings and conclusions." However, the Administrative Death Review noted: "The committee had no Administrative Recommendations."

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "When an individual is referred to Hospice, the family's wishes including performing an autopsy should be included in the end-of-life planning IDT meeting" resulted in an email to QIDPs asking them to read the recommendation. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not IDTs discussed individuals and families' wishes with them, and documented the decisions in end-of-life ISPAs.

Also, as noted above, important recommendations from the Quality Assurance Death Reviews were not carried forward into Administrative or Clinical Death Reviews, and therefore, they were not tracked through to completion.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.

Summary: The Monitoring Team will review these indicators until the Center's quality assurance/improvement mechanisms related to ADRs can be assessed, and are deemed to meet the requirements of the Settlement Agreement.

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
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.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/1			0/1						
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/1			0/1						
d.	Reportable ADRs are sent to MedWatch.	N/A			N/A						

Comments: a. and b. On 1/29/16, Individual #13 started prophylactic Cipro for a Targis procedure. On 1/31/16, facial swelling was noted. Based on the Monitoring Team's document request, on 2/1/16, the Center provided IPN documentation, but there was no entry from the PCP related to a Cipro allergy and facial swelling. However, on 2/3/16, the PCP documented that the individual had right peri-orbital edema and old bruising. This was assessed as a facial injury of unknown etiology. It was not clear if this was related to the previous reports of facial swelling. It should be noted that there was no follow-up related to this finding.

c. On 2/8/16, the Pharmacist completed a review of the potential ADR. The physician review date was not documented. The physician review section indicated: "no data" for all three fields. Although the Pharmacy and Therapeutics Committee minutes included discussion of two ADRs, they did not include discussion of Individual #13's 1/31/16 ADR.

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: DUEs should consistently include findings. In addition, recommendations should be generated, as appropriate, and followed through to closure.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	67% 2/3
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/3

Comments: a. and b. Lufkin SSLC submitted documentation related to three DUEs, including:

- Dilantin Follow-up DUE, dated 1/1/16;
- Inhaled Tobramycin DUE, dated 4/28/16; and
- Diastat DUE, dated 7/1/16.

Based on review of the documentation submitted, from January 2016 to October 2016, the Center completed two clinically relevant DUEs. The January 2016 DUE was a follow-up related to Dilantin use. A single-page graph was submitted. There was no narrative. Therefore, the Center did not provide the Monitoring Team with objective findings and recommendations to review.

The objective of the Inhaled Tobramycin DUE was to review utilization of the medication for the prevention of pneumonia and the significance of drug safety monitoring and efficacy and adverse events of this medication at Lufkin SSLC. The use of inhaled tobramycin for three individuals was reviewed. The recommendation was to "consider initiating an inhaled tobramycin trial in a larger group for six months to obtain more substantial data regarding efficacy." Criterion for inclusion was that individuals be considered high risk for pneumonia. High risk was defined as three or more hospitalizations for respiratory illness in the past six months. There is no medical literature to support the use of inhaled tobramycin for the population designated by the inclusion criterion. During the onsite review, the Monitoring Team expressed its concerns about the implication that the Center was initiating a clinical trial. In an email, dated 10/24/16, the Compliance Manager indicated: "The center is going to add an addendum to the DUE to make it clear there is no intent to have a trial."

The Center submitted Pharmacy and Therapeutics Committee meeting minutes for the meeting held on 7/7/16. They included two comments related to DUEs. Under old business, it was noted that the DUE follow-up on tobramycin was deferred. Under the DUE section, it was documented that the Clinical Pharmacist presented the Diastat DUE. There was no documentation of the discussion related to the DUEs. Therefore, it was not clear what, if any, actions the Committee would take relative to the recommendations presented. Moreover, the Center did not provide any evidence of action plans associated with any of the DUEs completed. No other minutes were submitted.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Fifteen of these indicators, in psychiatry, behavioral health, medical, dental, nursing, and skill acquisition, had sustained high performance scores and will be moved the category of requiring less oversight. This included no entire outcomes.

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

Assessments

For half of the individuals, the IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting. Similarly, for half of the individuals, the team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.

For the individuals' risks reviewed, none of the IDTs effectively used supporting clinical data (including comparisons from year to year), used the risk guidelines when determining a risk level, and/or as appropriate, provided clinical justification for exceptions to the guidelines. As a result, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

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

Additional work was needed with regard to the quality of medical assessments. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, address family history, and include plans of care for each active medical problem, when appropriate.

For this review and the previous two reviews, Dental Department staff generally completed dental exams and summaries for the individuals reviewed in a timely manner. The related indicators will be placed in the category requiring less oversight. Although some progress was noted, the Center needs to continue to focus on the quality of dental exams, and dental summaries.

Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible. In addition, often, when individuals experienced changes of status, nurses did not complete assessments consistent with current standards of practice.

The PNMT was not consistently providing needed reviews and/or assessments for individuals with physical and nutritional management-related needs that met criteria for referral to and/or review by the PNMT. In addition, when the PNMT completed assessments, they were not timely, and many issues were identified with regard to the quality of the assessments. For example, the PNMT had not consistently identified the etiology/cause of the problem, and the steps necessary to mitigate risk. Data was not up-to-date and/or the PNMT did not conduct needed assessments, such as updated head-of-bed evaluations (HOBEs). The PNMT often did not clearly define individualized clinical indicators to assist IDTs in identifying when the individual was healthy and/or when deterioration was potentially occurring. In addition, disciplines that should have been involved in the PNMT assessment were not. The Center should focus on ensuring that individuals who need PNMT involvement have it, and on improving the quality of the PNMT's reviews and assessments.

The Center should focus on both the timeliness and quality of OT/PT assessments.

This facility had stable psychiatric staffing. This was a strength of the Lufkin SSLC and had been for quite some time. As a result, psychiatrists knew the individuals and their staff. Psychiatry department support staff, however, were new. Turnover in this part of the psychiatry department contributed to scheduling and paperwork requirements not meeting criteria. New hires were completing orientation.

Every individual had a comprehensive psychiatric evaluation, however, the content did not meet criteria, likely due at least in part, to the turnover in the psychiatry department support staff.

Individualized Support Plans

For the most part, staff with whom the Monitoring Teams interacted during the onsite week were very familiar with the supports included in individual's ISPs.

ISP QIDP department was well staffed with QIDPs who were active and engaged and motivated, QIDP facilitators for annual ISP meetings, QIDP supervisors, a QIDP educator, and a new QIDP coordinator. Given these resources, much progress should be demonstrated by the time of the next onsite review.

There remained a real need for action plans to support/line-up with the personal goal. There were many examples of creative

personal goals, but the action plans were not related to the personal goal. To be more precise, this is indicator 8 in ISP outcome 3. Similarly, action plans/action steps did not meet the various other criteria that in outcome 3. There are 11 indicators in this outcome, all of them are about the set of action plans, that is, the set of all action plans across all of the goals. The QIDP department should be sure that the set of action plans meet the criteria for these 11 indicators.

For no individual, was the ISP implemented within 30 days of the meeting, nor did the IDT review and revise the ISP as needed.

Overall, the IHCPs of the individuals reviewed were not sufficient to meet their needs. Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs, as well as nursing and physical and nutritional support interventions.

The development of individualized psychiatric goals was being addressed by state office. Over the next few months, those activities should impact Lufkin SSLC's psychiatric goals and move them towards meeting criteria with these indicators.

Every individual who needed a PBSP had a PBSP and goals/objectives were measurable and were based upon assessments. PBSPs were implemented timely and were current.

Individuals had two or three skill acquisition plans. Important areas of focus for the facility are ensuring that SAPs are based on assessment results; are practical, functional, and meaningful; and that reliable and valid data are available.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but progress was evident as described below. All six ISPs, for instance, included at least one goal that met criteria, and two ISPs had four goal areas that met criteria. This was very good progress since the last review. Focus is needed to ensure that goals are written in a way that can be measured (i.e., its achievement can be determined) and that data are collected. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	145	401	97	259	511	294			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	1/6	4/6	2/6	4/6	3/6	3/6			

2	The personal goals are measurable.	0% 0/6	1/6	3/6	1/6	3/6	2/6	2/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	1/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #145, Individual #401, Individual #97, Individual #259, Individual #511, and Individual #294. 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.

1. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

There was a lot of improvement, overall, in the individualization of personal goals. Each individual had at least one goal in one area that met criterion with this indicator. Two individuals had goals that met criterion in four of the six areas. All six individuals had goals that met criterion in the community living options area.

None of the six individuals had individualized goals in all six areas, therefore, none had a comprehensive set of goals that met criterion. Outcomes for the six ISPs remained very limited in scope and provided few opportunities to learn new skills or ensure that the individual would be involved in meaningful activity. Individuals at the facility spent the greatest part of their day wandering around the facility or unengaged in the home. Thus, it was unlikely that personal goals developed by the IDT would have a significant impact on their day.

To be specific, these goals met criterion:

- Individual #145: living options
- Individual #401: leisure, relationships, day/work, living options
- Individual #97: relationships, living options
- Individual #259: leisure, relationships, day/work, living options
- Individual #511: relationships, independence, living options
- Individual #294: leisure, independence, living options

Further, a number of goals were individualized and based on preferences and strengths. These included:

- Individual #401's leisure goal to attend three outdoor musical concerts in the community.
- Individual #145's living option goal to live in a small group home near her mother.

- Individual #259's leisure goal to become a member of a church in the community.
- Individual #294's independence goal to launder her clothes.

Other goals appeared to be individualized, but were not necessarily based on preferences. For example,

- Individual #401 has a goal to obtain community employment, however, there was no discussion regarding what type of employment Individual #401 was interested in obtaining. Her vocational assessment had not been updated prior to the ISP meeting to establish her vocational preferences and interests.
- Individual #97 had a day programming goal to present himself in the 524 classroom one time per week. The IDT did not identify activities that would interest Individual #97 and provide opportunities for skill building.
- Individual #259 had a goal for greater independence to not break his glasses for an entire quarter. This appeared to be a compliance based goal rather that a skill building goal.

2. Overall, personal goals for the ISPs did not meet the criterion described above in indicator 1. When a personal goal does not meet criterion, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. Of the 17 personal goals that met criterion for indicator 1, 12 also met criterion for measurability. The five goals that did not meet criteria for measurability included:

- Individual #401's goal to establish a new relationship with a peer.
- Individual #97's relationship goal to stay with his family two to three times per year.
- Individual #259's relationship goal to state appropriate ways to interact with females.
- Individual #511's goal to finish playing Connect 4.
- Individual #294's relationship goal to establish a relationship with another peer in her home.

3. For the 12 goals that were determined to be measurable, only one had reliable and valid data available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals. Individual #511's goal for greater independence had consistent data for determining progress.

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

Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met. Indicators 11 and 14 showed some improvement since the last review. These indicators will remain in active monitoring and should be a focus of the facility's for the next review.

Individuals:

#	Indicator	Overall Score	145	401	97	259	511	294			
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	2/6	0/6	1/6	1/6	2/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	67% 4/6	0/1	1/1	1/1	0/1	1/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	33% 2/6	0/1	1/1	0/1	1/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	2/6	0/6	0/6			

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

For the 17 personal goals that did meet criterion under indicator 1, seven met criterion for this indicator. Examples include:

- Individual #511's action plans to apply sunscreen supported his goal for greater independence.
- The action plans for Individual #294's independence goal included skill acquisition that would support the goal of independence in laundry.
- Individual #145 had a positive behavior support plan in place to address barriers identified by the team to achieving her living option goal.

Examples of action plans that were unlikely to support achievement of personal goals included:

- Individual #401, Individual #259, Individual #97, Individual #511, and Individual #294 did not have action plans in place to address barriers to achieving living options goals.
- Individual #259's action plan to support his relationship goal was not measurable, so it was unlikely to lead to achievement of his goal.

An area of focus for Lufkin SSLC is to ensure that each personal goal has action plans that specifically related to, and support, each specific personal goal. Inclusion of additional action plans that are related to the goal area are good to include, but there should always be action plans specific for each personal goal, too. This was also evident at the various ISP meetings attended by the Monitoring Team, including Individual #122; this was discussed with the QIDP and QIDP facilitator after the ISP meeting.

9. Preferences and opportunities for choice were not integrated in the individuals' ISP action plans.

10. ISP action plans not did comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the six individuals. No action plans were identified that clearly supported decision-making skills.

11. Four individuals had action plans to support greater independence.
- Individual #145's ISP did not include a rationale for her action plan to write her name. It was not clear how this would support her to become more independent. Her action plan to leave the medication cart appeared to be a compliance issue, not something that would lead to greater independence. A SAP was not developed to support her action plan for pedestrian safety, which might have led to greater independence.
- Individual #259 had a money management goal to support his greater independence. Observation of SAP implementation indicated that he already had money management skills targeted by his action plans. His team supported his move to the community after high school graduation this year. There are many skills that the IDT could focus on to support his greater independence in the community, including using community resources, housekeeping, cooking, banking, shopping, decision making, and job seeking skills.

12. IDTs did not fully integrate strategies to minimize risks in ISP action plans. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. Examples where strategies were not integrated in the ISP included:
- Individual #145's behavior support strategies were not integrated into teaching strategies for SAPs.
- Individual #401's ISP did not address her aspiration risk related to her GERD diagnosis.
- Recommendation in Individual #97's annual medical exam to address constipation were not integrated into his ISP.
- Individual #259's behavioral support strategies were not integrated into his community participation action plans.
- Individual #511 and Individual #294's strategies to minimize risk were in the IHCP, but not integrated into important areas of service and support. Integration into the ISP would vary for each individual, but typically would include supports to address risks within teaching and support strategies (SAPs) for any related training, action plans for work, community outings, and in discussion of community living options. For example, Individual #294 has mobility strategies to address her risk for falls. These should be integrated into her SAP for walking. They should also be referenced in plans for community outings (e.g., bowling, attending mass), as well as noted as supports needed if moving into the community. Similarly, her strategies from her PBSP should be integrated into other goals and action plans, as relevant. For Individual #511, his SAPs reference following his

PBSP, but specific strategies relevant to the SAP being taught should be spelled out for staff for when they implement the SAP. His IHCP also references his enteral feeding and positioning schedule. This information should be considered when scheduling implementation of other action plans in the ISP.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated. In addition to the examples provided in #11 and #12 above, examples included:

- For Individual #145, Individual #511, Individual #97, and Individual #294, communication strategies were not integrated into goals and action plans.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were few specific plans for community participation that would have promoted any meaningful integration for any individual. The exceptions were:

- Individual #259 had a goal to attend church in the community.
- Individual #401 had action plans to get her hair and nails done in the community.

15. One of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Although the IDT had not identified Individual #401's specific preferences for work, Individual #401 did have a personal goal to gain employment in the community. Action plans included a vocational assessment. This should have been completed prior to the ISP meeting to determine her specific employment preferences.

16. None of six ISPs had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Observations did not support that individuals had opportunities to spend a majority of their day engaged in functional or meaningful activities. Day programming was rarely based on an adequate assessment of preferences or skills, but rather chosen from a limited list of opportunities for programming offered by the facility.

The statewide focus upon engagement had not yet come to Lufkin SSLC. With that support, Lufkin SSLC may develop additional activities and opportunities on campus, as well as in the community. Further, that focus may also help direct support professionals to support great engagement throughout the day, in all types of contexts and situations.

17. Barriers to various outcomes were not consistently identified and addressed in the ISP. In particular, living options barriers were frequently not addressed with individualized and measurable action plans.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs were often missing key elements, as described elsewhere in this report. Living options action plans generally had no measurable outcomes related to awareness.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.	
Summary: Criterion was met for some indicators for some individuals, but overall, more work was needed to ensure that all of the activities occurred related to	Individuals:

supporting most integrated setting practices within the ISP. Primary areas of focus are the conduct of a thorough discussion of living options, and the identification and implementation of actions to address obstacles to referral. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	145	401	97	259	511	294			
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).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	50% 1/2	N/A	N/A	N/A	1/1	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	33% 2/6	0/1	0/1	0/1	1/1	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	0/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	50% 3/6	0/1	1/1	1/1	1/1	0/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	50% 1/2	N/A	N/A	N/A	0/1	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 to referral, or if the individual was currently referred, to transition.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1			
Comments:											

19. All six ISPs included a description of the individual's preference and how that was determined. This was an area of significant improvement for Lufkin SSLC.

20. The Monitoring Team observed Individual #259's annual ISP meeting. His preference for where to live was described and this preference appeared to have been determined in an adequate manner. The Monitoring Team also observed the annual ISP meeting for Individual #122. His preference was not determined and the IDT indicated that he had no knowledge. Further, his LAR made the determination that he not go on community living tours. At the ISP meeting, the team asked him if he'd rather live at the facility or somewhere else. As one would expect, he was unable to answer this question.

21. Two of six ISPs fully included the opinions and recommendation of the IDT's staff members.

- Individual #145's ISP noted that individual team members agreed that she could be served in the community. The summary statement, however, indicated that her behavior was a barrier to placement.
- Individual #401 and Individual #97's ISPs included individual opinions from team members, however, they were not supported by rationale and did not include recommendations in all cases.
- Individual #294's ISP did not include a recommendation from her PCP regarding community placement. Given her complex medical needs, the team should have considered recommendations from her PCP.

22. Five of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Individual #401's statement did not include the opinion of her LAR.

23. None of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths.

24. Three 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.

- Individual #145's ISP did not define behavioral/psychiatric supports that were barriers to referral.
- Individual #511's ISP indicated that LAR choice was the only barrier, however, other barriers were identified in his assessments.
- Individual #294's ISP indicated that she was referred for community placement and there were no barriers to referral. According to the QIDP, the IDT had not yet acted on the referral because they were waiting for her sister (who did not agree with the referral) to gain guardianship.

25. The Monitoring Team observed Individual #259's ISP annual meeting while onsite. The IDT did not develop a comprehensive list of potential barriers. For Individual #122, the IDT noted his LAR's choice for him to live at the facility.

26. None of the six individuals had individualized, measurable action plans to address obstacles to referral.

27. The Monitoring Team observed Individual #259's annual ISP meeting. Action plans were not clearly spelled out during his ISP meeting. The team identified his behavior as a barrier to placement, however, did not set measurable goals. The team did not set any actions for Individual #122.

28. See Indicator 26 above. The LAR's choice was identified as a barrier for Individual #401, Individual #97, Individual #259, and Individual #294. None of the IDTs developed a plan to educate the LAR on specific living options that might better support the individuals. Although all ISPs included generic visits into the community, individualized exposure to other living options was not considered.

29. Individual #294 had been referred to the community. Her ISP did not include specific action plans to move forward with the referral.

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

Summary: ISPs were revised annually, but not implemented in a timely manner, and some aspects were not implemented at all. Not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 145	401	97	259	511	294			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6	1/1	0/1	0/1	1/1	1/1	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	1/1	0/1	0/1	1/1			

Comments:

30. ISPs were developed on a timely basis.

32. Action plans were not implemented on a timely basis for any of the individuals. Examples in which timeliness criteria were not met included:

- For Individual #145, her work outcome was not implemented from February 2016 through April 2016. It was discontinued in May 2016. Action plans for her relationship goal were not implemented until May 2016. Her pedestrian safety SAP was only implemented one time in March 2016.
- Individual #401's QIDP monthly reviews indicated that action plans from the previous ISP were still being implemented in May 2016 and June 2016. Her ISP was developed in April 2016.

- There was no documentation submitted to support that Individual #97's action plan to shampoo his hair and exit the van from November 2015 through January 2016 were implemented.
- There was no documentation that Individual #259's goal to attend church in the community was implemented within 30 days of ISP development.
- No implementation data were available for July 2016 for Individual #511's SAP to apply sunscreen. His ISP was developed in June 2016.
- Individual #294's goal to launder her clothing was not implemented within 30 days of development.

33. Four of six individuals participated in their ISP meetings. Individual #401 and Individual #97 did not attend their meetings.

34. Individuals did not consistently have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples included:

- For Individual #145, no participation by DSP, day, or vocational staff.
- For Individual #401, no participation by day program staff. (She had frequent program refusals; input by day program staff could benefit team discussion regarding programming.)
- For Individual #259, no input from his psychiatrist.
- For Individual #511, no attendance by OT/PT, SLP, dietician, PCP, psychiatry, or day program staff.
- For Individual #294, no participation by her PCP or dietician.

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

Summary: Considering and obtaining needed assessments prior to the ISP remained an area in need of attention. There was a decrease in performance for indicator 35; indicator 36 was at the same level of performance at the time of the last review. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	145	401	97	259	511	294			
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.	50% 3/6	0/1	0/1	0/1	1/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	50% 3/6	1/1	0/1	1/1	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 three of six individuals. Examples of those that did not meet criterion were:

- Individual #145's IDT did not identify her need for an updated vocational assessment. The team developed a vocational goal that was never implemented, and then requested a vocational assessment in three months after her ISP meeting to determine

her work preferences.

- Individual #401's IDT did not discuss her need for further assessment to determine the cause of her frequent vomiting. Her last MOSES assessment was completed in 2014, but not identified and needed by the IDT.
- Individual #97's last vocational assessment was in 2011. Recommendations from that assessment were no longer relevant. The ISP preparation document indicated that he did not need an updated assessment.

36. For three of six individuals, IDTs did not arrange for and obtain needed, relevant assessments prior to the IDT meeting. Examples for which this did not occur were:

- Individual #401's behavioral assessment was submitted late. Her vocational assessment was not completed.
- Individual #511's QDRR was submitted late.
- Individual #294's QDRR was submitted late and her vocational assessment was not completed until after her annual ISP meeting.

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

Summary: It was good to see that QIDPs were now more regularly completing monthly reviews (indicator 38), but what was still needed were actions to be taken and regular revisions of the ISP as needed. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 145	401	97	259	511	294			
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 did not consistently meet to respond to various events, behavioral incidents, and medical issues, or to review progress or revise supports and services as needed. Reliable and valid data were seldom available to guide decision-making, in any event. As noted throughout this report, little progress was made towards achieving personal goals.

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

- Individual #511's OT evaluation noted multiple incidents of emesis between 1/18/16 and 4/26/16. His QIDP confirmed this information. His team did not meet to discuss this until after his hospitalization in May 2016. His team also failed to meet when he was not making progress on his goals.
- Individual #401's IDT only met once over the past six months. The IDT did not meet to discuss her lack of progress on goals or

frequent program refusals.

- Individual #145's monthly reviews indicated that her community goals were not consistently implemented due to staff shortages and her lack of money. The IDT did not meet to address these barriers to implementation.
- Both Individual #401 and Individual #145 were reviewed in detail by both Monitoring Teams. Concerns about the lack of comprehensive review of their cases were brought forward to the facility director during the onsite review. As a result, additional IDT meetings occurred and were scheduled for the week following the onsite review.

Recently initiated weekly house IDT meetings, called core team meetings, may set the occasion for more timely and complete responses to the types of events described above.

38. Overall, QIDPs were completing monthly reviews, however, there was rarely data available to determine progress towards meeting goals. QIDPs rarely documented action taken when there was a lack of progress or inconsistent implementation.

QIDPs recently began using the IRIS system to populate monthly reviews of services. There was still quite a bit of inconsistency in how this information was being used. The QIDPs will need to be sure that they are not only gathering data for the month, but also summarizing progress and revising the ISP as needed. Many individuals remained needlessly at risk due to the failure of IDTs to analyze data and revise supports when needed.

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

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

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
a.	The individual's risk rating is accurate.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #145 – choking, and dental; Individual #511 – constipation/bowel obstruction, and circulatory; Individual # – aspiration, and cardiac disease; Individual #401 – gastrointestinal (GI) problems, and skin integrity; Individual #592 – GI problems, and weight; Individual #240 – respiratory compromise, and GI problems; Individual #119 – constipation/bowel obstruction, and seizures; Individual #404 – constipation/bowel obstruction, and circulatory; and Individual #294 – infections, and other: pain].

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

provided clinical justification for exceptions to the guidelines.

b. For the individuals the Monitoring Team reviewed, it often appeared that the IDTs had not updated the IRRFs at least annually to reflect information/data to describe the individual's status over the year. In addition, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate.

Psychiatry

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

Summary: The development of individualized psychiatric goals was being addressed by state office. Over the next few months, those activities should impact Lufkin SSLC's psychiatric goals and move them towards meeting criteria with these indicators. The stability in the psychiatric provider staff should positively impact the ability for the facility to make progress on these indicators. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 65	145	222	401	97	259	3	124	210
4	The individual has goals/objectives related to psychiatric status.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1

Comments:

4-7. Psychiatry related goals for individuals, when present, 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. The data will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

Psychiatry, however, had begun to include goals in the quarterly medication reviews. This was good to see as it was a start. The goals were focused on reductions in problematic behaviors (e.g., reductions in self injurious behavior) and must be focused on psychiatric symptoms related to a particular diagnosis (i.e., what the facilities have come to call psychiatric indicators). In addition, these goals were not integrated into the individual's overall treatment plan via the IHCP or the IRRF.

Psychiatric progress notes indicated that the available data were reviewed. Discussions with facility staff revealed concerns regarding the validity and integrity of data. These concerns had increased following the implementation of the electronic health record, IRIS. This may be attributed to the novelty of the electronic record and the need for staff to become better acquainted with the system. In addition, as there is a shift to include psychiatric symptom data, the facility staff will need to determine how these symptoms will be monitored. Rating scales normed for individuals with developmental disabilities could be considered.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: All individuals had CPEs, as was the case for the two previous reviews, too. Therefore, indicator 12 will be moved to the category of requiring less oversight. The other four indicators showed decreased performance compared with the previous review. This may be due, at least in part, to changes in psychiatry department support staff. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 65	145	222	401	97	259	3	124	210
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	33% 3/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1
14	CPE content is comprehensive.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	67% 2/3	1/1	N/A	1/1	N/A	N/A	0/1	N/A	N/A	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.	62% 5/8	1/1	0/1	0/1	1/1	1/1	1/1	N/A	0/1	1/1

Comments:

14. In lieu of the CPE, the facility psychiatric staff had begun writing an initial psychiatric review note. These documents were located in four individual's records. These documents were generated on the day of admission and, as such, were incomplete with regard to the physical examination and laboratory examinations. While it is good that the individual's were evaluated promptly, the psychiatrist must do an addendum or revise the note to include the required information.

The Monitoring Team looks for 14 components in the CPE. Seven of the evaluations lacked a sufficient bio-psycho-social formulation. This was the most common deficiency. One evaluation was lacking sufficient information in a total of six elements, two evaluations

were lacking sufficient information in five elements, one evaluation was lacking sufficient information in three elements, three evaluations were lacking sufficient information in two elements, and two evaluations were lacking sufficient information in one element. It should be noted that the evaluations missing the most elements were performed in 2011 and 2012.

15. For the three individuals admitted since 1/1/14, three had psychiatric evaluations performed on the day of admission. Two individuals had a progress note from nursing authored on the day of admission and there was documentation that the initial medical assessment was performed on the day of admission. For the third individual, it was noted that the required information (e.g., the IPN from the day of admission) was not available in the record.

16. There was a need for improvement with regard to the consistency of diagnoses.

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

Summary: Psychiatric treatment documentation was updated within the past 12 months and this documentation was submitted to the IDT in a timely manner before the annual ISP. This had been occurring at Lufkin SSLC for some time and, therefore, indicators 17 and 19 will move to the category of requiring less oversight. Psychiatry department attendance, indicator 20, might move to the category of requiring less oversight after the next review if performance is maintained at a high level. The other two indicators were not at criterion and reflected the need for documentation improvement. These will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
17	Status and treatment document was updated within past 12 months.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	38% 3/8	1/1	0/1	0/1	0/1	1/1	1/1	N/A	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	87% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	0/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1

Comments:

17. All individuals had evaluations performed in a timely manner.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. The evaluations that did not meet criteria were missing the derivation of symptoms and also reference to the psychological/behavioral health assessment for one individual (Individual #145).

19. This item was scored utilizing the previous year's annual evaluation and previous year's ISP documentation for two individuals (Individual #259, Individual #97). In the ISP documentation regarding Individual #210, there was good documentation regarding the psychiatric clinician's contribution to the meeting.

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.

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

Summary: None of the individuals had a PSP. This indicator will remain in active monitoring and may be reviewed at the next review.

#	Indicator	Overall Score	Individuals: 65	145	222	401	97	259	3	124	210
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

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

Summary: One individual met all five criteria for this outcome. Additional attention and focus should result in these indicators all improving to 100% for the next review. Indicator 29 showed much progress since the last review. All five indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 65	145	222	401	97	259	3	124	210
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	75% 6/8	1/1	1/1	1/1	1/1	0/1	0/1	N/A	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	25% 2/8	0/1	0/1	0/1	1/1	0/1	0/1	N/A	1/1	0/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	13% 1/8	0/1	0/1	0/1	1/1	0/1	0/1	N/A	0/1	0/1

32	HRC review was obtained prior to implementation and annually.	75% 6/8	1/1	1/1	1/1	1/1	0/1	0/1	N/A	1/1	1/1

Comments:
28. For two individuals, Individual #97 and Individual #259, consent forms currently in use were expired.

29. The consent forms included adequate side effect information and included documentation of a medication information sheet with side effect information that was attached to the consent document.

30-31. The risk versus benefit discussion was not regularly included in the consent form. This information was located in the psychiatric quarterly. Alternate and non-pharmacological interventions were not regularly included. These omissions resulted in the lower scores for those individuals.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Lufkin SSLC ensured that every individual who needed a PBSP had a PBSP and that the PBSPs had goals/objectives as per criteria and that goals/objectives were measurable and were based upon assessments. This had been the case at the facility for a number of consecutive reviews for three indicators and, therefore, indicators 1, 2, and 3 will move to the category of requiring less oversight. With sustained performance, indicator 4 might move to this category after the next review. Indicator 5 showed progress since the last two reviews. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
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.	100% 14/14	1/1	1/1	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% 9/9	1/1	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% 9/9	1/1	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	1/1

		9/9									
5	Reliable and valid data are available that report/summarize the individual's status and progress.	67% 6/9	1/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, 14 required and had a PBSP (nine of the individuals reviewed by the behavioral health Monitoring Team and five individuals reviewed by the physical health Monitoring Team).

2-4. All individuals with a PBSP had measurable objectives related to behavioral health services that were based on assessment results

5. Six individuals had evidence of interobserver agreement (IOA) and data collection timeliness assessments in the last six months that were at or above 80%, indicating that their PBSP data were reliable. Individual #222 did not have an IOA assessment in the last six months. Individual #3 and Individual #124's most recent IOA and data collection timeliness assessments were below 80%.

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

Summary: The facility showed good performance on all three indicators. Moreover, all three showed improvement compare with the last two reviews, too. With sustained performance, all three indicators might move to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 65	145	222	401	97	259	3	124	210
10	The individual has a current, and complete annual behavioral health update.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
11	The functional assessment is current (within the past 12 months).	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
12	The functional assessment is complete.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
10. Eight individuals had current and complete annual behavioral health assessments. Individual #124's behavioral health update was updated within the last 12 months, however, the majority of the information was more than two years old.

11. Eight individuals had current functional assessments, Individual #124's indirect assessment, however, was dated 2014, and no rationale why it was not updated.

12. The Monitoring Team was encouraged that all functional assessments were complete, and well written.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: PBSPs were implemented timely and were current. This had been the case at Lufkin SSLC for the past two reviews, too, and therefore, both indicators 13 and 14 will be moved to the category of requiring less oversight. The completeness of the PBSP, indicator 15, showed good improvement across the past reviews and with sustained performance might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	100% 9/9	1/1	1/1	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.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
Comments: 15. The monitoring team reviews 13 components in the evaluation of an effective behavior support plan. Eight of the nine PBSPs contained all of those components. Individual #97's replacement behavior was not functional, and there was not a rationale for why a functional replacement behavior was not practical or functional. Additionally, his treatment interventions were not consistent with the functions hypothesized in the functional assessment.											

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: Counseling therapy services were recently re-initiated for individuals at Lufkin SSLC. None of the individuals chosen for review by the Monitoring Team needed or were receiving counseling services. Given the re-initiation of services, these indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
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	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	N/A
Comments: 24-25. None of the individuals reviewed received counseling services. The facility, however, had recently hired a counseling psychologist who was providing supports to five other individuals with the expectation that it might be increased to other individuals if needed.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely medical assessments (Round 9 – 100%, Round 10 – 100%, and Round 11 -100%), Indicators a and b will move to the category of requiring less oversight. Indicator c for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
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 periodic medical reviews, based on their individualized needs, but no less than every six months	Not rated (N/R)									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Additional work was needed with regard to the quality of medical assessments. Given that over the last two review periods and during this review, individuals reviewed generally had diagnoses justified by appropriate criteria (Round 9 – 89% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11 - 94% for Indicator 3.b), Indicator b will move to the category of requiring less oversight. Indicator c for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

b.	Individual's diagnoses are justified by appropriate criteria.	94% 17/18	2/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

Comments: a. Problems varied across the medical assessments the Monitoring Team reviewed. However, areas of particular weakness included:

- Family history – often, individuals reviewed had involved family, but family history was incomplete and/or had not been updated for years; and
- When appropriate, plans of care for each active problem – Only two of the nine individuals had complete plans of care for each active problem (i.e., Individual #145, and Individual #240).

b. 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 generally present for the diagnoses reviewed. The exception was diastolic heart failure for Individual #13, which is now known as HFpEF (heart failure with preserved ejection fraction).

c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

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

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
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.	33% 6/18	2/2	1/2	0/2	0/2	0/2	0/2	1/2	1/2	1/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

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 #145 – osteoporosis, and constipation/bowel obstruction; Individual #511 – osteoporosis, and cardiac disease; Individual #13 – gastrointestinal (GI) problems, and cardiac disease; Individual #401 – GI problems, and cardiac disease; Individual #592 – osteoporosis, and cardiac disease; Individual #240 – GI problems, and seizures; Individual #119 – cardiac disease, and seizures; Individual #404 – osteoporosis, and other: hypothyroidism; and Individual #294 – GI problems, and aspiration].

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

current standards of practice consistent with risk-benefit considerations were those for: Individual #145 – osteoporosis, and constipation/bowel obstruction; Individual #511 – osteoporosis; Individual #119 – seizures; Individual #404 – osteoporosis; and Individual #294 – GI problems.

b. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Dental

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

Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely dental examinations (Round 9 – 100%, Round 10 – 89%, and Round 11 - 100%) and dental summaries (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), Indicator a will move to the category of requiring less oversight. Although some work was still needed, it was positive to see improvement with the dental summaries. Although some progress was noted, the Center needs to continue to focus on the quality of dental exams.

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
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.	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	22% 2/9	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	63% 5/8	0/1	0/1	N/A	1/1	1/1	0/1	1/1	1/1	1/1

Comments: a. For Individual #13, who was at low risk for dental and who was in the outcome sample, the "deep review" items were not scored. For the remaining eight individuals reviewed, it was positive that the Dental Department completed timely dental exams and summaries.

b. It was good to see that the dental exams for two individuals the Monitoring Team reviewed contained all of the necessary

components (i.e., Individual #145, and Individual #592). On a positive note, all dental exams reviewed included, as applicable, a description of the individual's cooperation; an oral cancer screening; an oral hygiene rating completed prior to treatment; information regarding the last x-ray(s) and type of x-ray, including the date; a description of periodontal condition; an odontogram; caries risk; periodontal risk; specific treatment provided; the recall frequency; and a treatment plan. Problems varied with regard to dental exams, however, staff in the Dental Department should focus on ensuring exams include, as applicable, a description of sedation use, periodontal charting; and a summary of the number of teeth present/missing.

c. It was positive to see some improvement with the dental summaries reviewed. For Individual #145, Individual #511, and Individual #240, the oral health instruction sections indicated that improvement was needed, but did not provide instruction on what was needed or how improvement should be approached. In addition, the Center continues to need to review its definition of refusals. The current definition only addresses if an individual refuses to leave the home, but not if he/she refuses treatment upon arrival at the Dental Clinic. The Center needs to use the broader definition.

Nursing

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

Summary: Given that over the last two review periods and during this review, individuals reviewed had timely comprehensive nursing assessments (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), Indicators a.i. and a.ii. will move to the category of requiring less oversight. The remaining indicators require continued focus to ensure nurses complete timely quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which	56% 5/6	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1

	the quarterlies are due.										
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that for the nine individuals reviewed, nursing staff completed timely annual comprehensive nursing reviews and physical assessments. Some problems were noted with regard to the quarterly nursing record reviews and physical assessments, including incomplete physical assessments (i.e., Individual #240, and Individual #294), the incorrect individual's documentation provided (i.e., Individual #511), and a missing quarterly weight record (i.e., Individual #592). Of note, the majority of assessments did not denote if the pulse oximetry findings were obtained on room air or not.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #145 – choking, and dental; Individual #511 – constipation/bowel obstruction, and circulatory; Individual # – aspiration, and cardiac disease; Individual #401 – GI problems, and skin integrity; Individual #592 – GI problems, and weight; Individual #240 – respiratory compromise, and GI problems; Individual #119 – constipation/bowel obstruction, and seizures; Individual #404 – constipation/bowel obstruction, and circulatory; and Individual #294 – infections, and other: pain).

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

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

- For Individual #511, a nursing IPN, dated 4/3/16, reported: "a heart rate of 31, and only came up to 40s" and "very lethargic." Nursing staff notified the physician. The physician ordered a check of the individual's pulse every five minutes for two hours, and an EKG, and noted "2-3+ pitting edema bilateral LE [lower extremities]." On 4/4/16, nursing staff documented the individual's pulse rates, but there was no evidence nursing staff assessed his peripheral edema, or level of consciousness. The next nursing IPN in the record was dated 4/7/16.
- For Individual #13, an ISPA, dated 5/25/16, noted the individual was sleeping through both shifts of work, and the IDT recommended he be given his new blood pressure medication at night. No corresponding nursing assessments or IPNs included information about his sleep issues, and the medical IPNs did not indicate that nursing staff had communicated the IDT's recommendation to the PCP. No physician order was found showing that the time for the blood pressure medication was changed.

- On 7/27/16, another individual bit Individual #401. The initial nursing assessment, dated 7/27/16, indicated Individual #401 said: "it hurts a little bit." The nurse took no actions to review the Medication Administration Record (MAR) for possible pro re nata (PRN, or "as needed") pain medication. The nursing IPN did not document notification of the Infection Control Preventionist regarding the human bite that broke the skin, review of the individual's immunization record, notification of the physician, and/or placement of the individual on the sick-call list.
- On 7/15/16 at 3:05 a.m., Individual #240 had an episode of emesis. The nursing IPN noted: "v/s [vital signs] 97, R [respirations] 18, unable to obtain rest of vital signs d/t [due to] aggressive behavior." The Nursing IPN indicated the physician was notified, and orders received. Given Individual #240's health risk and the symptoms reported (i.e., "bleeding, vomiting, and coughing"), nursing staff should have followed up with additional attempts to obtain vital signs and more frequent assessments of his status. Nurses do not need a physician's order to obtain vital signs, or institute more frequent assessments. It was not until 7/15/16 at 6:45 am. that the next IPN was documented. Nursing IPNs leading up to this event (i.e., 7/11/16 to 7/15/15) were missing or nonexistent. Individual #240 died on 7/16/16 with cause of death listed as septic shock, right lower lobe pneumonia, aspiration, and rectal bleeding requiring blood.
- According to a medical IPN, Individual #404 had a Methicillin-resistant Staphylococcus aureus (MRSA) skin infection on her nostril requiring antibiotic ointment. Nursing staff did not develop an acute care plan, and they did not follow acceptable standards of care when observing and documenting size, response to treatment, and infection control practices. Nursing staff did not complete and/or document ongoing skin assessments to monitor the lesions and determine whether or not new lesions were appearing.
- For Individual #294, a 7/11/16 nursing IPN documented that the individual "has been receiving Clindamycin for ulcer of ear with cellulites since 7/8/16." This was the first mention in the nursing IPNs regarding antibiotic therapy for her skin integrity condition. Nursing staff did not follow nursing guidelines/standards of care for antibiotic therapy, infection control practices, and/or monitoring for pain. Of concern, no acute care plan was found for this serious issue that required an urgent visit to the Ear, Nose, and Throat (ENT) specialist with sedation.

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

Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0/18									
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: None.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: The PNMT was not consistently providing needed reviews and/or assessments for individuals with physical and nutritional management-related needs that met criteria for referral to and/or review by the PNMT. In addition, when the PNMT completed assessments, they were not timely, and many issues were identified with regard to the quality of the assessments. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
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% 0/5	0/1	0/1	0/1	N/A	N/A	0/1	0/1	N/A	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	20% 1/5	0/1	1/1	0/1			0/1	0/1		N/A
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4	N/A	0/1	0/1			0/1	0/1		N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	40% 2/5	1/1	1/1	0/1			0/1	0/1		N/A
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	25% 1/4	N/A	0/1	0/1			0/1	N/A		1/1
f.	Individuals receive review/assessment with the collaboration of	0%	0/1	0/1	0/1			0/1	0/1		N/A

	disciplines needed to address the identified issue.	0/5									
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	0/1	N/A	0/1			N/A	N/A		N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	N/A	0/1	0/1			0/1	0/1		N/A

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

- Because the PNMT conducted a review of Individual #145 on 8/2/16, it appeared she had been referred to the PNMT. However, documentation was not clear with regard to when she was referred, or when she met the threshold for referral. A noted indicated that on 7/28/16, a "threshold review" was conducted, but it was unclear who did it, or how the IDT or PNMT identified that she met the threshold. No IPNs, no ISPA, and no PNMT meeting minutes addressed this beyond the actual review document. The PNMT review included no evidence of medical/pharmacy staff participation in relation to medication side effects, and/or Behavioral Health Services (BHS) staff participation in relation to behavior beyond merely referencing previous documentation by psychiatry and BHS.
- According to the most recent PNMT assessment, on 1/20/16, Individual #511's diagnosis of bronchitis was changed to aspiration pneumonia. However, he was not referred to the PNMT at that time. Another qualifying hospitalization occurred between 4/27/16 and 5/11/16, but the IDT did not refer the individual to the PNMT until 5/17/16. On the same day of the referral, the PNMT initiated an assessment. On 6/30/16, the PNMT completed the assessment. No evidence was submitted to show the PNMT discussed the RN post-hospitalization review. There was no evidence of medical staff participation in the PNMT assessment in relation to GERD and "bronchitis management."
- On 2/2/16, Individual #13 had aspiration pneumonia, and on 2/16/16, he was discharged from the hospital. His IDT did not refer him to the PNMT, and the PNMT did not initiate a self-referral. No evidence was found of an RN post-hospitalization review or timely PNMT review of such a review. On 2/22/16, the IDT held a post-hospitalization ISPA meeting. However, documentation showed that the IDT's discussion pertained primarily to falls, and did not also address the issue of aspiration pneumonia. It was not until 3/16/16 that this episode was reviewed through the Center's pneumonia review process. Even then, Individual #13 was not referred to the PNMT.
- According to the PNMT assessment, on 1/7/16, seven days after his discharge from the hospital for aspiration pneumonia on 12/31/15, Individual #240 was referred to the PNMT. Documentation indicated that on 1/15/16, the PNMT decided to complete a comprehensive assessment, but that after further review, the PNMT decided to only complete a consult. The PNMT provided no viable rationale for this decision. On 2/19/16, the PNMT conducted its review, which referenced only the time

period from 1/22/16 through 2/9/16. Despite evidence of a number of qualifying hospitalizations, no evidence was found of RN post-hospitalization reviews.

A PNMT IPN, dated 3/11/16, documented that the consult was near completion, but on 2/29/16, Individual #240 had a hospitalization for pneumonia. The IPN stated: "no new recommendations at this time, PNMT to follow up in 2 weeks with complete consult evaluation." In the IPNs submitted, the Monitoring Team found no evidence of follow-up until 6/30/16, with the review period identified as 3/19/16 to 6/30/16. From 5/31/16 to 6/17/16, Individual #240 was hospitalized with bilateral aspiration pneumonia and numerous other diagnoses. He also was experiencing vomiting episodes. An assessment was submitted entitled "PNMT assessment," dated 6/23/16, with a signature date of 6/30/16. However, the PNMT never documented if or when they decided to do a more extensive assessment. An IDT meeting was scheduled for 7/7/16 to review PNMT findings, with the next review on 8/11/16. On 7/15/16, Individual #240 died at the age of 62 with causes of death listed as septic shock, right lower lobe pneumonia, aspiration, and rectal bleeding requiring blood.

- For Individual #119, the PNMT review, dated 5/12/16, was completed over three months after the review period of 8/1/15 to 1/31/16, during which 21 episodes of vomiting occurred. The PNMT did not provide clinical justification as to why they did not complete a comprehensive assessment, and instead completed a rather limited review more than three months after the need for one was established. Based on the complexity of Individual #119's presenting problems, the PNMT should have completed a comprehensive assessment. Moreover, the root cause for vomiting that the PNMT identified in its initial review was shown to be inaccurate. On 5/12/16, PNMT documentation stated that a GI series was ordered and they "hope" it will identify the root cause. This testing came nearly five months after the individual met the threshold for PNMT review. This delay was likely complicated by the fact that the PNMT did not appear to incorporate medical consultation into its review of the GI problems Individual #119 was experiencing.

g. Examples of problems noted included:

- For Individual #145, the PNMT review document did not specify the presenting problem, but it was inferred by the list of falls. Although the PNMT appeared to believe that the individual's falls were related to increased Valium, they did not justify why they concluded no further assessment was indicated. As noted above, a medical/pharmacy staff member was not part of the review process, which would be necessary to evaluate the impact of medication(s) on falls, and consider alternatives.
- The only evidence of PNMT review for Individual #13 was a PNMT RN IPN, dated 3/17/16, that indicated the Center's pneumonia review meeting to discuss his pneumonia was held on 3/16/16. It stated that root cause had been determined and that if he had another episode of aspiration pneumonia or signs of aspiration occurred, the PNMT would review him at that time. The PNMT should have reviewed this individual who had confirmed aspiration pneumonia.

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #13, and Individual #119). The two assessments that the PNMT did complete were of poor quality. The following provide some examples of problems noted:

- For Individual #240, the majority of the data the PNMT presented in the assessment, dated 6/30/16, was from 2015 and early 2016, despite the fact that in the subsequent months he had significant related issues. The PNMT's analysis of the presenting problem of emesis concluded it was due to secretions with no discussion as to how or why they arrived at this conclusion, and/or how secretions might contribute to the incidence of vomiting. The PNMT included extremely limited discussion of the

impact emesis had on respiratory issues during the last year, particularly from February through June 2016. Recommendations had little to do with secretions, and/or vomiting. Although the PNMT discussed secretion management, they offered no strategies other than consulting the PCP and Pharmacy Department. Discharge criteria were related to episodes of emesis (i.e., no more than one to three in three months). The PNMT established no re-referral or re-assessment criteria. The goal the PNMT presented was not measurable and did not address the root cause/etiology or related intervention strategies.

- For Individual #511, the PNMT provided no discussion regarding whether or not his behavior impacted the provision of PNM supports and services. Recommended goals were for Individual #511 to experience no pain related to GERD, no episodes of aspiration, and that exacerbations of bronchitis would be better controlled. These were not measurable, nor did they address the cause or etiology of the problems. The PNMT indicated re-assessment thresholds were for vomiting (i.e., PNMT referral criteria) or any aspiration episode, but did not establish more proactive indicators or early thresholds for action to prevent re-referral to the PNMT. Discharge criterion from the PNMT was only related to Individual #511 not having bronchitis in three consecutive months, although the PNMT assessment did not describe any baseline of bronchitis. An ISPA, dated 7/15/16, indicated that a head-of-bed evaluation (HOBE) would be done, but the PNMT had not addressed this need in the assessment. On 7/14/16, the PNMT reviewed Individual #511's assessment "in detail" two weeks after it was completed and the day before the scheduled meeting with his IDT. It was not until that time that they decided to complete a HOBE. This evaluation should have been completed as an aspect of the comprehensive assessment, or, at the very least, the PNMT assessment should have included it as a recommendation, particularly given that the PNMT analysis linked his GERD, vomiting, etc. to aspiration.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.

Summary: No improvement was seen with regard to the Center's performance with these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/7	0/1	0/1	0/1	N/A	N/A	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% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to	6%	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2

	take when they occur, if applicable.	1/18									
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: choking, and falls for Individual #145; falls, and aspiration for Individual #511; falls, and aspiration for Individual #13; choking, and falls for Individual #401; choking, and falls for Individual #592; aspiration, and GI problems for Individual #240; GI problems, and falls for Individual #119; aspiration, and fractures for Individual #404; and aspiration, and fractures for Individual #294.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exception was the IHCP for falls for Individual #13.

b. The IHCP that included preventative physical and nutritional management interventions to minimize the individuals' risks was for falls for Individual #13.

c. Seven individuals reviewed had PNMPs. Problems varied across these PNMPs. For example, it did not appear that the PNMPs for Individual #145 and Individual #13 had been updated in response to her PNMT review, and his change of status related to aspiration pneumonia, respectively; risk triggers were not identified and/or were inaccurately identified for all seven individuals; the wheelchair positioning pictures for Individual #511 and Individual #294 were too small for staff reference; Individual #13's transfer and/or mobility status were not specified, nor were positioning instructions provided for mealtime or bed; Individual #145's levels of independence with regard to toileting and bathing were not specified; some handling precautions were incomplete based on individuals' risk levels (i.e., Individual #404 related to her high fracture risk, and Individual #145 in relation to osteopenia); although Individual #13 had a separate Dining Plan, his PNMP did not include mealtime instructions; some did not define positioning during tooth brushing (i.e., Individual #511, Individual #240, and Individual #294); and Individual #13's PNMP did not indicate how staff should communicate with him.

f. The IHCP that identified triggers and actions to take should they occur was for GI problems for Individual #240.

g. The IHCP for choking for Individual #145 defined individualized PNMP monitoring.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: The Center had not made progress with these indicators.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical	0% 0/3	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A	0/1

	necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.										
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% 0/3		0/1				0/1			0/1
Comments: a. For the three individuals reviewed who received enteral nutrition, their IRRFs did not contain documentation to show the IDTs reviewed whether or not enteral nutrition continued to be the least restrictive method (i.e., Individual #511 and Individual #294), or the IDT had not provided clinical justification for the continued medical necessity of enteral nutrition (i.e., Individual #240). Individual #294's OT/PT assessment recommended an updated Modified Barium Swallow Study (MBSS), but no evidence was presented to show this occurred.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center should focus on both the timeliness and quality of OT/PT assessments.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
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/R				
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	63% 5/8	1/1	1/1	1/1	0/1		0/1	1/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	63% 5/8	1/1	1/1	1/1	0/1		0/1	1/1	0/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional	N/A									

	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.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/2	N/A	N/A	N/A	N/A		N/A	N/A	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/5	0/1	0/1	0/1	N/A		0/1	0/1	N/A	N/A

Comments: a. and b. Five of the eight individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following provide examples of concerns noted:

- For Individual #401, the Center did not submit a specialized assessment to justify the initiation of direct therapy for sensory integration. When the Monitoring Team member discussed this with Habilitation Therapies Department staff, they produced a document from their files. For purposes of this review, only assessments that are part of the individual's official record are considered. Of note, the assessment produced on site identified some level of concern with the individual's sensory integration, but indicated that the concern would be addressed through programming in Building 560 and not through direct therapy. Therefore, it remained unclear why direct therapy was initiated. Based on the documentation, the OT offered no suggestions as to how to implement programming in Building 560.
- For Individual #240, the Center submitted someone else's OT/PT assessment.

d. Individual #404's OT/PT assessment was not complete, and, as a result, scored negatively on all of the sub-indicators. Some of the problems related to Individual #294's comprehensive OT/PT assessment included: the OT/PT did not use the individual's preferences and strengths in the development of supports and services; the assessment addressed the PNMP supports related to risks from the perspective of assistive/adaptive equipment, but did not address specific strategies; although the assessment listed the individual's medications, it did not indicate whether or not she presented with side effects and/or whether they impacted her motor skill performance and/or participation in activities of daily living (ADLs); and the assessment merely stated that OT/PT services were not recommended without providing any clinical rationale.

e. As noted above, another individual's OT/PT assessment was submitted for Individual #240. Unfortunately, significant issues were

noted with regard to the quality of the OT/PT updates reviewed. The following summaries some examples of concerns noted with regard to the required components of OT/PT assessments:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs: For Individual #145 and Individual #119, the update did not discuss the impact that changes in the individual's health status had on her OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services: All of the updates reviewed merely listed the individuals' strengths and preferences, but did not use them in the development of supports or recommendations;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: For Individual #145, the update listed a number of falls, but did not discuss them in relation to risk or even cite her risk for falls. For Individual #119, the update did not report the incidence of falls;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For Individual #145, Individual #13, and Individual #119, the updates listed medications, but did not relate them or their potential or realized side effects to the individual and his/her motor skills;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day: Individual #145's OT/PT update did not include a thorough discussion of motor skill performance, and it did not discuss sensory strengths and deficits (even though a few months later, a Sensory Profile identified deficits related to touch). Individual #119's update described supports needs for ambulation/mobility, but did not provide a functional description of his abilities (e.g., gait analysis). Two pages of Individual #511's OT/PT update were missing (the update also was misfiled in Individual #240's documents);
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): For Individual #145, the update did not discuss the condition of her shoe inserts. As noted above, two pages of Individual #511's OT/PT update were missing. For Individual #119, the update did not address the condition of the wheelchair;
- 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: Individual #145's update did not relate her status to previous assessments. For Individual #119, the updated provided a comparison of his activities of daily living, but did not describe his gait (except in terms of supports required), and did not provide a comparison of gait from previous assessments;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Individual #145, and Individual #13 both had falls over the last year, but neither update provided analysis of the effectiveness of the PNMP. Again, two pages of Individual #511's OT/PT update were missing. Monitoring findings also were not consistently reflected (e.g., Individual #119);
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: Because individuals did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. Individual #13's update described gait issues that potentially were increasing his fall risk, but the update did not provide justification for why OT/PT services beyond the PNMP were not indicated. Similarly, without justification, Individual #145's update indicated she did not need OT/PT services, and Individual #119's update indicated he did not need PT services "unless his gait deteriorated enough to require increased

supports…"; and

- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Individual # 145's update included incomplete assessment data necessary to formulate recommendations. As noted above, Individual #13 and Individual #119's updates did not recommend PT services (e.g., direct or a SAP) to address identified gait issues, and provided no clinical justification. Again, two pages of Individual #511's OT/PT update were missing.

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

Summary: Since the last review, some regression was seen with regard to individuals' ISPs including functional descriptions of them from an OT/PT perspective, and at least annual review of individuals' PNMPs, Dining Plans, and/or Positioning Schedules. However, the Center showed improvement with regard to holding ISPA meetings when OT/PT supports were initiated outside of the ISP meeting.

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	25% 2/8	0/1	0/1	0/1	1/1	N/R	0/1	0/1	0/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	25% 2/8	1/1	0/1	0/1	0/1		0/1	1/1	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.	13% 1/8	0/1	0/1	1/1	0/1		0/1	0/1	0/1	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.	100% 3/3	1/1	N/A	N/A	2/2		N/A	N/A	N/A	N/A

Comments: None.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: The Center should focus on the timeliness as well as the quality of communication assessments and updates.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
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.	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									
	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.	33% 3/9	1/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	33% 3/9	1/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental	N/A									

	Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/4	0/1	N/A	N/A	0/1	0/1	N/A	0/1	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/5	N/A	0/1	0/1	N/A	N/A	0/1	N/A	0/1	0/1

Comments: a. and b. The following provides information about problems noted:

- Individual #511's last full assessment was completed in 2012. An update completed in 2014 did not meet the individual's needs. It indicated that his participation in direct therapy was minimal due to inadequate staffing and home quarantines. No recommendations were made regarding additional direct therapy trials, and/or further assessment. No more recent assessment was submitted, and no rationale for not completing one was documented.
- Individual #13's comprehensive communication assessment, dated 7/29/15, recommended an annual update, but no update was submitted.
- For Individual #401, a screening completed in 2014 included a recommendation for placement on the Master List as Priority 4 for a comprehensive assessment. There was no evidence that this was ever completed.
- For Individual #592, on 10/15/15, a communication assessment included a recommendation for direct therapy to begin in the spring of 2016. If Individual #592 required direct therapy, the IDT should have held an ISPA meeting to discuss initiation of the therapy. The Speech Language Pathologist (SLP) should then have provided the IDT information as to his progress for the ISP meeting held on 1/5/16.
- For Individual #240, the last comprehensive communication assessment, dated 2/25/14, recommended an annual update. On 2/4/15, an update was completed, but did not meet the individual's needs. In addition, a more current update should have been completed in February 2016.
- For Individual #404, a comprehensive communication assessment, dated 5/22/15, indicated that she would require an annual update and that her communication was significantly impacted by drowsiness. This was the rationale provided for her lack of interest in AAC and interaction. No more current update was provided.

d. As noted above, Individual #401 should have had a comprehensive assessment, but did not. The following describes some of the concerns with the remaining three assessments:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: although therapists listed these, they did not discuss how they did or did not specifically impact individuals' communication skills (e.g., Individual #119);
- The individual's preferences and strengths are used in the development of communication supports and services: assessments often listed strengths and preferences, but did not incorporate them into the development of supports. The only exception was the assessment for Individual #145;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: although therapists listed medications, they did not discuss how if side effects were present, they did or did not impact individuals' communication (e.g., Individual #119);
- The effectiveness of current supports, including monitoring findings: for Individual #592, it did not appear monitoring had

occurred;

- 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: in some cases, it was unclear whether additional assessment was needed (e.g., Individual #592), and/or whether AAC device assessment in more functional settings and throughout the day would have yielded different results (e.g., Individual #119);
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: no evidence was found of this for Individual #592); 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: justification was not provided for the recommendation that called for a three-month delay in providing direct therapy to Individual #592, or the lack of recommendations for a communication SAP for Individual #119.

On a positive note, all three assessments provided:

- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills; and
- A comparative analysis of current communication function with previous assessments.

e. As noted above, four individuals that should have had updates did not (i.e., Individual #511's, Individual #13's, Individual #240, and Individual #404). For Individual #294, problems included that the update did not provide specific information about how her medications impacted the individual and her communication, and did not adequately assess current supports (i.e., continued use of the communication builder in the day program or home).

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

Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	67% 6/9	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy	15%	0/4	0/1	N/A	0/1	1/4	N/A	0/2	N/A	1/1

	interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	2/13									
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	0% 0/5	0/4	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
Comments: a. Individual #294's ISP provided a much-improved example of how to address communication in an ISP.											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
Summary: Individuals had two or three skill acquisition plans. This was the case for this review and the last two reviews. Therefore, this indicator (1) will move to the category of requiring less oversight. The other four indicators will remain in active monitoring. Indicator 2, regarding measurability, might move to the category of requiring less oversight if high performance is sustained. The other three indicators showed improvement over the past reviews. Ensuring that SAPs are based on assessment results; are practical, functional, and meaningful; and reliable and valid data are available are important areas of focus for the facility.			Individuals:								
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
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.	96% 24/25	3/3	3/3	3/3	3/3	3/3	2/3	3/3	2/2	2/2
3	The individual's SAPs were based on assessment results.	88% 22/25	3/3	3/3	2/3	3/3	3/3	3/3	1/3	2/2	2/2
4	SAPs are practical, functional, and meaningful.	64% 16/25	1/3	3/3	2/3	3/3	1/3	1/3	1/3	2/2	2/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	20% 5/25	2/3	1/3	1/3	0/3	0/3	0/3	0/3	1/2	0/2
Comments: 1. All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. There were only two SAPs available to review for Individual #124 and Individual #210 for a total of 25 SAPs for this review. 2. Ninety-two percent of the SAPs were judged to be measurable (e.g., Individual #97's wash hands SAP). Individual #259's state											

appropriate action SAPs, however, did not have a behavioral objective.

3. Eighty-eight percent of the SAPs were based on assessment results. Individual #3's use a ledger and state appropriate use of the hotline SAPs and Individual #222's point to the picture SAP were inconsistent with their functional skills assessments which indicated they could independently complete the task.

4. Only 16 SAPs appeared to be practical and functional (e.g., Individual #401's dial the phone 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 #97's exit the van SAP), or assessment data indicated the individual already possessed the skill (e.g., Individual #222's point to a picture SAP). Ensuring that SAPs are practical and functional should be a priority for Lufkin SSLC.

5. The majority of SAPs did not have interobserver agreement (IOA) demonstrating that the data were reliable. The exception was Individual #65's state healthy food and state side effects of medications SAPs, Individual #145's write her name SAP, Individual #222's point to the picture SAP, and Individual #124's pour his drink SAP which had IOA above 80% and was assessed in the last six months. The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data). It is recommended that Lufkin SSLC establish the demonstration of reliable SAP data as a priority.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.

Summary: Improved performance was demonstrated for all three indicators, all of which might be moved to the category of requiring less oversight after the next review if high performance is maintained. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 65	145	222	401	97	259	3	124	210
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
10-12. All individuals had current FSAs, PSIs, and vocational assessments that included SAP recommendations. Additionally, only Individual #3's PSI was not available to the IDT at least 10 days prior to the ISP.

Domain #3: Individuals in the Target Population will achieve optimal physical, mental, and behavioral health and well-being through access to timely and appropriate clinical services.

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Twenty of these, in restraints (1), psychiatry (7), behavioral health (9), medical (1), and OTPT (2), had sustained high performance scores and will be moved the category of requiring less oversight. This included two outcomes: one in psychiatry and one in behavioral health.

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

Goals/Objectives and Review of Progress

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

In psychiatry, without measurable goals, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. One of the strengths of Lufkin SSLC's psychiatry department was its regular provision of clinics for individuals. Further, clinics were conducted in an integrated manner with good leadership from the psychiatrist. Psychiatric providers attended to the polypharmacy concerns of the individuals on their cases. Polypharmacy committee needed to be reinstated. There was mediocre performance on completing all aspects of the psychotropic medication side effect review process.

There were good reliable behavioral health data for six of the individuals. Graphic data were available and useful for the many different types of reviews that were occurring at Lufkin SSLC. The new electronic health record was implemented after the set of documents were submitted to the Monitoring Team; any resultant effects will be reviewed by the Monitoring Team next time.

Acute Illnesses/Occurrences

Variables that were identified as potentially playing a role in the occurrence of behaviors that often led to more than three restraints in any rolling 30-day period were identified and actions to address these variables were developed and taken.

When there was lack of progress and/or the ongoing exhibition of problem target behaviors, the behavioral health services department took action.

With regard to acute illnesses/occurrences, improvement was needed with regard to nursing staff's assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis until the issue resolved; timely notification of the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification; the development of acute care plans for all relevant acute care needs; and development of acute care plans that are consistent with the current generally accepted standards.

Overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Center and/or in other settings varied, and for many individuals reviewed, significant concerns were noted. On a positive note, over the last two review periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse generally communicated necessary clinical information with hospital staff.

Implementation of Plans

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

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs. The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessments, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. These treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

During this review and the last one, for some of the consultations reviewed, problems were noted with regard to the PCPs reviewing consultations and indicating agreement or disagreement, doing so in a timely manner, and writing an IPN that included necessary components. The Center also needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs, including the clinical justification for their decisions.

The Center also needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Some problems were noted for the individuals' reviewed with regard to dental care and treatment. The Center should focus on ensuring individuals receive necessary prophylactic dental care, x-rays, and treatment for periodontal disease. On a positive note, improvements were noted with regard to the dentist's assessment of the need for dentures for individuals with missing teeth.

With regard to Quarterly Drug Regimen Reviews (QDRRs), for a number of individuals reviewed, the Pharmacy Department left the lab section blank; did not address labs needed for specific drugs (e.g., eye exams for Seroquel); and/or did not further review abnormal lab results to determine significance followed by recommendations, if clinically appropriate. It was good to see that prescribers reviewed QDRRs timely, and documented agreement or provided a clinical justification for lack of agreement with Pharmacy's recommendations. When prescribers agreed to recommendations for the individuals reviewed, they implemented them.

Adaptive equipment was generally clean and in good working order. The two related indicators will move to the category of requiring less oversight. Proper fit was sometimes still an issue.

Staff compliance with PNMP implementation showed an 8% reduction from the last review (i.e., from 76% to 68%). This continues to be an area in which focused efforts are needed, because PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

PBSP summaries were available for float staff. Some, but not all, staff in all settings were shown to have received training on the individual's PBSP.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.												
Summary: Criteria were met for six indicators for both individuals. One of these indicators also met criteria for the past two reviews and will be moved to the category of requiring less oversight (indicator 24). The other indicators will remain in active monitoring. At this point, Lufkin SSLC should be able to meet all of the criteria for this outcome for all individuals.			Individuals:									
#	Indicator	Overall Score	145	3								
18	If the individual reviewed had more than three crisis intervention	100%	1/1	1/1								

	restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	2/2									
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 2/2	1/1	1/1							
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	50% 1/2	1/1	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 them.	50% 1/2	1/1	0/1							
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2	1/1	1/1							
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	50% 1/2	1/1	0/1							
26	The PBSP was complete.	N/A	N/A	N/A							
27	The crisis intervention plan was complete.	100% 1/1	1/1	N/A							
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 2/2	1/1	1/1							

29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 2/2	1/1	1/1							

Comments:
18-29. This outcome and its indicators applied to Individual #145 and Individual #3.

18-19. Both individuals that had more than three restraints in 30 days had ISPAs to address those restraints within 10 business days. Additionally, a sufficient number of ISPAs existed for developing and evaluating their plan to address each individual's restraints.

20. Individual #145's ISPA following more than three restraints in 30 days reflected a discussion of potential adaptive skills, and biological, medical, and/or psychosocial issues, and actions to address them in the future. Individual #3's ISPA following more than three restraints in 30 days reviewed his adaptive skills, and biological, medical, and/or psychosocial issues, however, the minutes did not indicate how, or if, these issues contributed to his dangerous behaviors that provoked restraint.

21. Individual #145 and Individual #3's ISPAs following more than three restraints in 30 days reflected a discussion of contributing environmental variables, however, no actions to address these contributing environmental variables in the future was documented.

22. Neither of the ISPAs included a discussion of potential antecedents' contribution to each individual's restraints.

23. Individual #145's ISPA reflected a discussion among the IDT of potential variables maintaining the dangerous behavior provoking each individual's restraints, and a plan to address them. Individual #3's ISPA, however, did not reflect a discussion by his IDT concerning the role of maintaining variables.

25. Individual #3 did not have a crisis intervention plan.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: Reiss screens were conducted as required for this review and for the previous two reviews, too, including for change of status. During the two previous reviews, indicators 2 and 3 were also scored at 100%, with but one exception regarding documentation for indicator 3. Therefore, all three of the indicators of this outcome will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	404	3							
1	If not receiving psychiatric services, a Reiss was conducted.	100% 2/2	1/1	1/1							

2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	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.	100% 1/1	N/A	1/1							

Comments:
1-3. Of the 16 individuals reviewed by both Monitoring Teams, two individuals were not receiving psychiatric services. One of these individuals, Individual #404, was screened via the Reiss in 2013; no additional services were necessary. Individual #3 was screened on admission and received a psychiatric evaluation. He was later discharged from psychiatry clinic. These two individuals were score for these indicators.

Another individual, Individual #13, was initially screened in 2012. At that time, no services were necessary. A second Reiss screen was performed in 2015. At that time, he was referred to psychiatry and continued to receive psychiatric services. Reportedly, this subsequent screen was not performed as a result of a change in status.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
8	The individual is making progress and/or maintaining stability.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1

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

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments, suggestions for non-pharmacologic approaches) were developed and implemented. This was good to see and had been occurring for many years at Lufkin SSLC. For instance, some individuals were put on a regular weekly scheduled psychiatry clinic rather than waiting for the IDT to have to call a

more emergency-based meeting.

Discussion at Individual #145's psychiatry clinic during the onsite review included conducting a re-evaluation of her diagnoses, which could lead to new treatment decisions.

There was concern because Individual #3 was discharged from psychiatry clinic following the initial evaluation. This individual had a history of psychiatric diagnoses and treatment with psychotropic medications. Medications trialed previously had not been particularly helpful and he was currently refusing treatment with medication. This does not relieve psychiatry of the need to continue to monitor this individual for an exacerbation of symptoms. This might be done through the IDT process.

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

Summary: Scoring for indicator 23 was impacted by one individual not having had a PBSP in place for five months when a PBSP should have been in place. Both will remain in active monitoring, though with improved and sustained high performance, both might move to the category of requiring less oversight after the next review.

Individuals:

#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	75% 6/8	1/1	1/1	0/1	0/1	1/1	1/1	N/A	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1

Comments:
23. The psychiatric quarterly clinical documentation referenced the behavioral health target behaviors. The functional behavioral assessment discussed the role of the psychiatric disorder upon the presentation of the target behaviors. In the case of Individual #222, a diagnosis of anxiety was not included in the functional behavioral assessment. In the case of Individual #401, there was a five month period where there was no active PBSP.

24. In all cases, the psychiatrist referenced the PBSP in quarterly clinical documentation.

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

Summary: These three indicators were at about the same level of performance as during the past review. With additional focus, it is likely that these indicators can show improved performance. All four will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	75% 3/4	N/A	N/A	N/A	1/1	1/1	N/A	N/A	1/1	0/1
26	Frequency was at least annual.	75% 3/4	N/A	N/A	N/A	1/1	1/1	N/A	N/A	1/1	0/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	50% 2/4	N/A	N/A	N/A	1/1	0/1	N/A	N/A	1/1	0/1

Comments:
25-27. This outcome addresses the coordination between psychiatry and neurology. These indicators applied to four of the individuals. Individual #210 was scheduled for neurology clinic on multiple occasions, but had refused to attend. There was documentation of the psychiatric clinician seeing this individual in his home. There was no documentation of this level of effort on the part of neurology.

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

Summary: One of the strengths of Lufkin SSLC's psychiatry department was its regular provision of clinics for individuals. Further, clinics were conducted in an integrated manner with good leadership from the psychiatrist. As a result, indicator 33 was scored 100% at this review and the last two reviews, and indicator 35 at this review and the last review, and a high score at the January 2016 review. Thus both indicators, 33 and 35, will be moved to the category of requiring less oversight. Indicator 34 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
33	Quarterly reviews were completed quarterly.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
34	Quarterly reviews contained required content.	50% 4/8	0/1	0/1	0/1	0/1	1/1	1/1	N/A	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 5/5	1/1	1/1	1/1	1/1	N/A	N/A	N/A	1/1	N/A

Comments:
34. The Monitoring Team looks for nine components of the quarterly review. Four of the reviews were missing one to three components; most commonly, a review of the implementation of non-pharmacological interventions. In the most recent quarterly review regarding Individual #401, it was noted that the MOSES assessment was long overdue, last being documented in October 2014.

35. Psychiatry clinic was observed for five individuals. In all of these examples, there was good clinical discussion, and the various criteria were met, however, data were not specifically utilized in decision making for medication adjustments.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: The facility maintained mediocre performance on this indicator, primarily due to the schedule/ability of the department to ensure review by the primary care physician. A look at the system for doing so is recommended. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	25% 2/8	1/1	0/1	1/1	0/1	0/1	0/1	N/A	0/1	0/1
Comments: 36. Assessments were generally occurring in a timely manner. As noted above, however, there was a significant delay in the assessments for Individual #401. Criteria were not met because there were deficiencies noted in the psychiatry review of the completed assessments. Also, there was no documentation of PCP review.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: Not all individuals required emergency or interim psychiatry clinics. One individual did, and received these every week. One other individual should have had an interim clinic, but it did not occur. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
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	1/1	1/1	N/A	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	50% 1/2	N/A	1/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	50% 1/2	N/A	1/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A
Comments: 37-39. A strength of the facility's psychiatry department is that the psychiatric providers individualize psychiatry clinic scheduling, such as holding a weekly clinic for individuals who are in need. This was evident at the last review and again at this review (for Individual #145). For Individual #259, however, following the December 2015 quarterly clinic, it was noted that the psychiatrist would see him in one week. There was no documentation that this occurred.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These important indicators showed good performance for this review and for the previous two reviews, with one exception detailed below. They will remain in active monitoring and may be considered for movement to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	87% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	N/A	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	87% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	N/A	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: 41-42. In the case of Individual #401, there was a five month period where psychotropic medications were prescribed in the absence of a current PBSP, resulting in these two indicators not meet criteria for her. Further, as indicated in various places in this report, a comprehensive review of Individual #401's status was not done, but needed to occur. After prompting from the Monitoring Team, a review was held and another was to be held during the week following the onsite review.											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary: Psychiatric providers attended to the polypharmacy concerns of the individuals on their cases. This has been the case for a number of years at Lufkin SSLC. Therefore, indicators 44 and 45 will be moved to the category of requiring less oversight. The facility, however, needs to reinstate and implement the polypharmacy committee and the important role it plays in the management of psychiatric medication. That indicator, 46, will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 4/4	1/1	N/A	N/A	1/1	N/A	1/1	N/A	1/1	N/A
45	There is a tapering plan, or rationale for why not.	100% 4/4	1/1	N/A	N/A	1/1	N/A	1/1	N/A	1/1	N/A

46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	25% 1/4	0/1	N/A	N/A	0/1	N/A	0/1	N/A	1/1	N/A

Comments:
44-45. These indicators applied to four individuals. Polypharmacy justification was appropriately documented in the psychiatric clinical documentation in all cases. In addition, tapering plans were in place for other individuals, too, even if their medication regimen did not meet the definition of polypharmacy. This was good to see.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for one individual meeting criteria for polypharmacy. There was discussion during the onsite monitoring visit that, due to clerical support issues, there were difficulties with scheduling for polypharmacy meetings and with other psychiatry-clinical scheduling. All psychiatry support positions were filled approximately two weeks prior to this visit. Psychiatry staff were aware of the delinquencies and planned to resume regular reviews.

Psychology/behavioral health

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

Summary: Lufkin SSLC had good reliable data for six of the individuals. This was good to see and one of them was making progress. The other five were not making progress and for the remaining three, progress could not be determined due to the absence of good reliable data. The Monitoring Team scored indicators 8 and 9 based upon the facility's report of progress/lack of progress as well as the ongoing exhibition of problem target behaviors. For these individuals, the facility identified and took action. This was also the case during the last two reviews, too, and therefore, indicators 8 and 9 will move to the category of requiring less oversight. Indicators 6 and 7 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
6	The individual is making expected progress	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
9	Activity and/or revisions to treatment were implemented.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A

		8/8									

Comments:
6. Only Individual #210 was scored as making progress.

7. Individual #210 achieved his self-injurious objective in May 2016, however, no new objectives were established.

8-9. Individual #65, Individual #145, Individual #222, Individual #401, Individual #97, Individual #259, Individual #3, and Individual #124 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.

Summary: Documentation of training of staff continued to improve compared to the two previous reviews, but continued focus will be required. The other two indicators in this outcome, regarding a PBSP summary and the qualifications of behavioral specialists were at 100% for this and the previous two reviews. These indicators, 17 and 18, will be moved to the category of requiring less oversight. Indicator 16 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
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.	44% 4/9	0/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	1/1
17	There was a PBSP summary for float staff.	100% 9/9	1/1	1/1	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% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
16. Individual #145, Individual #222, Individual #3, and Individual #210 had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) working in their residence were trained on their PBSPs.

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

Summary: Reviewing progress and ensuring that graphic data are useful for the many different types of reviews was occurring at Lufkin SSLC as demonstrated by 100% performance on all five indicators of this outcome. This was the case for the previous reviews, too (with one exception, which was indicator 20 with a 89% score in April 2015). Therefore, this outcome and its five indicators will be moved to the

Individuals:

category of requiring less oversight.											
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
19	The individual's progress note comments on the progress of the individual.	100% 9/9	1/1	1/1	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% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 5/5	1/1	1/1	1/1	N/A	N/A	N/A	1/1	1/1	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% 1/1	N/A	1/1	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 #65, Individual #145, Individual #222, and Individual #124's psychiatric clinic meetings, and Individual #3's Behavior Support Committee meeting. In all five meetings, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team.

22. Individual #145 had a previous peer review. There was evidence that data collection changes suggested in her peer review were implemented.

23. In order to score this indicator, the Monitoring Team observed Individual #3's peer review. Individual #3 was reviewed because he was not making expected improvements. His peer review included the review of his PBSP and most recent behavioral data. There was participation and discussion by the behavioral health services team. Additionally, Lufkin SSLC had documentation that internal peer review meetings were consistently occurring weekly, and external peer review meetings were occurring monthly.

Outcome 8 – Data are collected correctly and reliably.	
Summary: Lufkin SSLC had a solid data collection system that collected data in a reliable, individualized, and flexible manner. Various measures of the data system were being conducted and goals were set, though not yet met for all individuals. Overall, this was good to see. Given that the new electronic health record was	Individuals:

implemented on 8/8/16, any resultant effects were not in the documents reviewed by the Monitoring Team. However, while onsite, a number of logistical and implementation challenges were observed by the Monitoring Team. Therefore, these indicators will remain in active monitoring. With sustained performance, indicators 26-29 might move to the category of requiring less oversight after the next review.											
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9	1/1	1/1	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% 9/9	1/1	1/1	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% 9/9	1/1	1/1	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% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	33% 3/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1

Comments:

26-27. This indicator is based on the data collection system that was in place as of through 7/31/16. 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 #145, Individual #97, and Individual #210. Individual #222 did not have IOA assessed this quarter, and the last assessment of Individual #3 and Individual #124's data collection timeliness and IOA was under 80%. Individual #65, Individual #401, and Individual #259 had CIPs. Individual #65 did not have IOA, data collection timeliness, or treatment integrity monthly. Individual #401 and Individual #259 did not have monthly IOA measures. Ensuring that the established IOA, data collection timeliness, and treatment integrity measures should be a priority for Lufkin SSLC.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs generally did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #145 – osteoporosis, and constipation/bowel obstruction; Individual #511 – osteoporosis, and cardiac disease; Individual #13 – GI problems, and cardiac disease; Individual #401 – GI problems, and cardiac disease; Individual #592 – osteoporosis, and cardiac disease; Individual #240 – GI problems, and seizures; Individual #119 – cardiac disease, and seizures; Individual #404 – osteoporosis, and other: hypothyroidism; and Individual #294 – GI problems, and aspiration).

None of the goals/objectives were clinically relevant, achievable, and measurable.

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

Outcome 4 – Individuals receive preventative care.											
Summary: One of the nine individuals reviewed received the preventative care they needed. Over this and the previous two review periods, the Center has shown some variability with these scores. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, the Facility needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1
	ii. Colorectal cancer screening	100% 6/6	1/1	1/1	1/1	N/A	N/A	1/1	1/1	N/A	1/1
	iii. Breast cancer screening	75% 3/4	1/1	N/A	N/A	0/1	N/A	N/A	N/A	1/1	1/1
	iv. Vision screen	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	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	44% 4/9	1/1	0/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1
	vii. Cervical cancer screening	0% 0/4	0/1	N/A	N/A	0/1	N/A	N/A	N/A	0/1	0/1
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	N/A
Comments: a. Examples of problems included: • For Individual #145, a 10/1/14 gynecological exam noted an enlarged uterus with a plan to return in a year. No documentation was presented to show the individual returned. A Pap smear report also was not submitted for the 2014 visit. • For Individual #511, a 4/26/16 DEXA report noted progression of osteoporosis, but no plan was submitted to address this											

finding.

- For Individual #13, the DEXA scan, dated 5/20/16, showed osteoporosis of each proximal femur. The bone mineral density (BMD) had decreased by 2% since the prior study. Osteopenia of the lumbar spine also was noted. However, the PCP made no changes to the treatment and made no referral to endocrinology.
- On 6/5/15, Individual #401 had a mammogram with a recommendation to return in a year, but documentation was not found of a more recent test. The report for the Pap smear completed on 4/16/14 indicated it was unsatisfactory for evaluation.
- Individual #240 did not have documentation of Prevnar 13 administration. He had a DEXA scan in 2011, but refused a repeat evaluation in 2014 with no documentation of repeated attempts.
- On 12/12/14, Individual #119 had a vision exam with a recommendation to return in a year, but no documentation was found of a more recent screening.
- On 2/18/16, documentation indicated Individual #404 had a non-reactive Hepatitis B surface antibody, but the annual medical assessment did not include a plan to address it. The PCP also did not address a decrease in BMD. Cervical cancer screening stated "N/A," but no explanation was provided.
- For Individual #294, cervical cancer screening stated "N/A," but no explanation was provided. Although the annual medical assessment indicated Individual #294 had a DEXA scan on 1/26/16, the response to the Monitoring Team's request for a copy of the report stated: "N/A."

Comments: b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

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

Summary: The Monitoring Team will continue to review this indicator.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	0/1	N/A

Comments: a. For Individual #240, on 2/29/16, a DNR Order was implemented. The PCP wrote an IPN entry noting that the DNR was made at the family's request. The diagnosis was end stage renal disease and hospitalizations for various diagnosis including sepsis, pneumonia, and anemia. There was no documentation of discussion of renal replacement therapy, nor was it clear that the individual had end stage renal disease. In May and July 2016, multiple hospital documents included the diagnosis of chronic kidney disease Stage III and not end stage renal disease. On 7/15/16, Individual #240 died with causes of death listed as septic shock, right lower lobe pneumonia, aspiration, and rectal bleeding requiring blood.

On 4/29/16, a DNR was implemented for Individual #404. A verbal order was written: "renew DNR; Dx: DNR Renewal." The DNR form was signed on 4/3/14. The AMA included a comment that the DNR was implemented at the request of the family due to Acute/Chronic

Respiratory Failure. The active problem list did not document any respiratory conditions.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Given that over the last two review periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse communicated necessary clinical information with hospital staff (Round 9 – 100% for Indicator 4.f, Round 10 – 100% for Indicator 4.f, and Round 11 - 100% for Indicator 6.f), Indicator f will move to the category of requiring less oversight. However, overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Center and/or in other settings varied, and for many individuals reviewed, significant concerns were noted. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
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.	7% 1/14	0/2	0/2	0/1	0/2	0/2	1/1	0/2	0/1	0/1
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.	7% 1/14	0/2	1/2	0/1	0/2	0/2	0/1	0/2	0/1	0/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	70% 7/10	N/A	1/1	1/2	N/A	N/A	2/2	2/2	1/1	0/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	83% 5/6		1/1	N/A			2/2	1/1	1/1	0/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	70% 7/10		1/1	2/2			0/2	2/2	1/1	1/2
f.	If individual is transferred to the hospital, PCP or nurse	100%		1/1	2/2			2/2	2/2	1/1	2/2

	communicates necessary clinical information with hospital staff.	10/10									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	60% 3/5		0/1	1/1			2/2	N/A	N/A	0/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	10% 1/10		0/1	0/2			1/2	0/2	0/1	0/2

Comments: a. and b. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 14 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #145 (facial injury on 2/16/16, and lacerations on 7/28/16), Individual #511 (drop in heart rate and lethargy on 4/3/16, and cellulitis on 4/18/16), Individual #13 (muscle sprain on 6/22/16), Individual #401 (facial laceration on 4/14/16, and cellulitis on 4/29/16), Individual #592 (constipation on 5/16/16, and nasal contusion on 4/6/16), Individual #240 (wound to right abdomen on 2/22/16), Individual #119 (facial hematoma on 3/1/16, and upper respiratory infection on 3/9/16), Individual #404 (peripheral edema on 2/4/16), and Individual #294 (hypotension on 6/5/16).

The acute illness for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice was for Individual #240 (wound to right abdomen on 2/22/16). For many of the remaining acute illnesses treated at the Center that the Monitoring Team reviewed, numerous problems were noted. Some examples are provided below.

The acute illness/occurrence reviewed for which follow-up was needed, and documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized was for Individual #511 (cellulitis on 4/18/16).

The following provide some examples of concerns noted:

- On 7/28/16, the PCP documented that Individual #145 fell and sustained a laceration to the top of her head. This note was not written in Subjective, Objective, Assessment, and Plan (SOAP) format, but noted that a four-centimeter (cm) laceration was present on the top of the individual's head. Bleeding was mild with minor swelling. The plan was "see injury report." There was no documentation of an appropriate physical exam, inclusive of vital signs and a neurological exam. There was no detail about the wound, such as the depth and no documentation of how the wound would be repaired. Nursing notes indicated the wound was closed with dermabond, but the Advanced Practice Registered Nurse (APRN) did not document any cleansing or repair of the wound.
- On 4/4/16, Individual #511's PCP documented that nursing staff reported the individual "had a drop in HR [heart rate] to 31 yesterday and was very lethargic." The individual's HR initially increased to the 40s, and when he was fully awake, it increased to 80s. The PCP noted there was no ability to do a continuous pulse check. There were no vital signs documented in the assessment. The plan was to check and record the individual's pulse for two hours and obtain an electrocardiogram (EKG). The results of the EKG were documented in an IPN entry, dated 4/5/16, and the plan was to check Individual #511's pulse when asleep and as needed for lethargy. Two weeks later on 4/18/16, the next PCP assessment was documented and it was for evaluation of cellulitis of the legs. The PCP initialed the EKG on 4/6/16. There was no further documentation or follow-up

related to bradycardia.

- On 4/16/16, nursing staff documented that both of Individual #511's lower extremities were red. The PCP was notified and gave a verbal order for Bactrim DS. Two days later on 4/18/16, the PCP documented redness and warmth to both lower extremities. The exam was limited and did not include vital signs, such as temperature. The diagnosis was cellulitis. The plan was to continue antibiotics and reevaluate on 4/26/16. On 4/19/16, another PCP documented no redness or swelling, and the antibiotics were discontinued. In summary, there was a two-day delay in completing an initial medical assessment. The assessment documented did not include important findings, such as neurovascular status of the extremities. There was no documentation of vital signs. Specifically, there was no temperature documented for an individual that was treated with systemic antibiotics for an infection. Less than 10 hours later, another PCP documented the absence of redness and warmth and discontinued antibiotics.
- On 4/14/16, nursing staff documented a 1.2-cm laceration to Individual #401's right brow. Steri-strips were applied. On 4/14/16, another nursing IPN noted an acute care plan was initiated. The PCP cosigned the nursing note. No medical assessment was documented. On 4/16/16, nursing staff noted that multiple attempts to contact the PCP were not successful, so another PCP was notified that the individual was pulling off the steri-stips. An order was given to apply "liquid bandage."
- On 5/16/16, Individual #592's PCP documented a complaint of constipation. It was documented that the x-ray showed a lot of stool in the colon; there was no abdominal pain, nausea, or vomiting. The abdomen was soft, round, and non-tender. The assessment was constipation and the plan was to start Senna, give Milk of Magnesia as needed, and recheck abdominal film on 5/23/16. There was no documentation of the follow-up in the IPNs. According to the quarterly medical summary, it appeared that a follow-up abdominal film was completed on 5/26/16. Given that the individual had a diagnosis of chronic constipation, the plan did not appear to comprehensively address this condition.
- On 4/6/16, the PCP noted Individual #592 was seen due to facial trauma secondary to an altercation. Nasal swelling and bleeding were documented, but the individual did not allow for a thorough exam. The plan was to give ibuprofen, apply ice packs, and obtain nasal x-rays. On 4/11/16, five days after the initial assessment, the PCP completed follow-up, and it was noted that the x-ray showed a "probable nasal bone fracture." On 4/15/16, an Ear, Nose, and Throat (ENT) consultant saw the individual, and the assessment was that the changes were fixed and further intervention was not recommended.
- On 3/9/16, Individual #119's PCP noted the individual had vomiting and coughing for two days. The assessment was vomiting and coughing. The plan was to continue as-needed promethazine, the proton pump inhibitor (PPI), and to obtain an abdominal x-ray. Tessalon perles were prescribed for the cough. The PCP did not document any vital signs for this examination. Although the PCP saw the individual for other issues (e.g., on 3/15/16, to assess a wound), the only related medical evaluation was done on 3/21/16, for allergic sinusitis.
- On 2/4/16, Individual #404's PCP documented the following: "S [Subjective] -med clinic for lower extremity edema; TSH [thyroid stimulating hormone]-nl [normal limits]; BNP [Brain natriuretic peptide]-nl; No H/o [history of] CHF [congestive heart failure]; O [Objective] -both lower extremities equally puffy, non-pitting; normal color, temperature; A [Assessment]-dependent edema; P [Plan] -normal finding for this individual who wears ted hose to address this issue." It is unclear if this particular PCP had evaluated the individual in the past. Regardless of this, there should have been a complete physical assessment documenting the findings of the heart and lung examinations since CHF appeared to be in the differential. A BNP would only be done in that instance. Furthermore, a normal BNP does not rule out congestive heart failure. On 3/22/16, the PCP documented chronic lower extremity edema that was dependent. The plan was to monitor for shortness of breath with edema. However there was no documentation of a physical exam to establish the cardiac and pulmonary status. The next documentation related

to the lower extremity edema was over three months later on 6/29/16. At that time, the edema was more fully addressed with documentation of cardiac and pulmonary findings.

- On 6/5/16, nursing staff documented that direct support professionals reported that Individual #294 had a light brownish nasal discharge. Vital signs were: blood pressure 87/64, 84/56, pulse 100, respiratory rate 24, oxygen saturation 96%. The nursing assessment was hypotension. The PCP was notified and the individual was placed on sick call. No orders were received/documented. On 6/6/15, the PCP documented that the individual was seen for nasal drainage, and decreased blood pressure. The assessment was hypotension resolved, no rhinorrhea; no treatment needed. The PCP did not conduct a follow-up evaluation.

For six of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #511 (aspiration pneumonia on 4/27/16), Individual #13 (aspiration pneumonia on 2/7/16, and tachycardia on 2/4/16), Individual #240 [upper gastrointestinal (GI) bleed on 3/18/16, and pneumonia on 5/31/16], Individual #119 (laceration on 3/5/16, and neurologic changes on 6/28/16), Individual #404 (bradycardia on 6/18/16), and Individual #294 (hand fracture on 3/7/16, and dehydration on 6/26/16).

c. The hospitalizations, ED visits, and/or Infirmary admissions for which the PCP or a provider did not complete a timely evaluation of the individual prior to the transfer, or if unable to assess prior to transfer, within one business day, did not complete an IPN with a summary of events leading up to the acute event and the disposition were for: Individual #13 (aspiration pneumonia on 2/7/16), and Individual #294 (hand fracture on 3/7/16, and dehydration on 6/26/16).

d. Four of the acute illnesses reviewed occurred after hours or on a weekend/holiday. For Individual #294's hand fracture on 3/7/16, which occurred during normal business hours, the PCP or a provider did not complete an evaluation.

e. For the acute illnesses reviewed, it was positive the individuals reviewed generally received timely treatment at the SSLC. The exceptions were Individual #240 (upper GI bleed on 3/18/16, and pneumonia on 5/31/16), and Individual #294 (dehydration on 6/26/16).

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

g. Concerns included:

- On 5/17/16, an ISPA meeting was held for Individual #511, and the IDT documented that the PCP was notified and invited, but did not participate. It would appear important to have medical input given the individual had an Intensive Care Unit admission for aspiration pneumonia and septic shock and experienced a rapid deterioration at the Center.
- After Individual #294's hospitalization on 6/26/16 for pneumonia and dehydration, the IDT held an ISPA meeting, and the PCP attended. However, the ISPA did not address how an individual who receives enteral nutrition became so severely dehydrated. In addition, there was no discussion of the pneumonia diagnosis included in the discharge summary.

h. For the individuals reviewed, upon their return to the Center, there was generally not evidence to show that 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. The exception was Individual #240's pneumonia on 5/31/16. Examples of problems included:

- On 3/17/16, the PCP documented Individual #240 had a hemoglobin result of 6.8 and this result was being faxed to the hematologist. The individual also was being referred to gastroenterology (GI) for evaluation due to the possibility of GI blood loss in addition to chronic renal failure. Per the PCP, "this is not a sudden drop so he can probably tolerate it while we proceed [with] this work up." However, the labs indicated that this was a significant drop in hemoglobin and hematocrit, which on 2/25/16 was 9.0/29.1 compared to 6.8/21.4 on 3/16/16. This was more than a two-gram (gm) drop in hemoglobin in three weeks. The PCP did not document a physical examination of the individual. There were no vital signs documented to determine if the individual was hemo-dynamically stable, and there was no rectal exam and testing of stool to determine the presence of GI bleeding. On 3/18/16, the PCP documented the individual had bloody emesis and lethargy and was being transferred to the ED. The individual was admitted with upper GI bleeding requiring transfusion of multiple units of blood, and anemia secondary to blood loss. On 4/8/16, he was discharged. On 4/9/16, the PCP completed a post-hospital assessment. The next assessment was on 4/13/16, and it was related to wounds on the right abdomen. On 4/14/16, the PCP documented two episodes of emesis.
- On 6/5/16, nursing staff documented that a direct support professional reported that Individual #294 had a light brownish nasal discharge. Vital signs were blood pressure 87/64, and 84/56, pulse 100, respiratory rate 24, and oxygen saturation 96%. The nursing assessment was hypotension. The PCP was notified and the individual was placed on sick call. No orders were received. On 6/6/16, the PCP documented that the individual was seen for nasal drainage, and decreased blood pressure. The assessment was resolved hypotension, no rhinorrhea, and no treatment needed. On 6/20/16, the PCP documented the individual was seen for ear pain "holding her ears with both hands close." There was no nausea or vomiting. According to the PCP, on 6/6/16, she was "treated for rhinorrhea or seen for rhinorrhea" and did not need medications. The assessment was left otitis media. The PCP was unable to visualize the right tympanic membrane. Augmentin and Ciprodex otic drops were prescribed. On 6/22/16, the PCP noted that the individual was evaluated for evidence of bilateral ear pain. The plan was to continue antibiotics obtain an ear culture, and the PCP prescribed a decongestant and Tylenol #3 with follow-up as needed. According to nursing documentation, on 6/23/16, Toradol intramuscular (IM) was ordered after two doses of Tylenol #3 appeared to provide no relief. At 3:45 p.m., nursing staff documented that the PCP was notified after medication administration that the individual was sweating and had abnormal vital signs (blood pressure 137/85, pulse 127), but the nurse noted the PCP: "stated she was busy with employee injury and would get back with me." At 6:10 p.m., the PCP completed an evaluation and noted the etiology of the pain was unclear. Labs were ordered. IM Rocephin was ordered. Atenolol 10 milligrams (mg) were given for the tachycardia and prednisone for inflammation. The plan was to follow-up in the morning, but the PCP did not document follow-up on 6/24/16 or 6/25/16. On 6/26/16, the PCP documented that the individual was seen for two reasons: 1) follow-up of pain, which had not been explained, and which has not responded to Tylenol #3, Toradol, prednisone, and antibiotics; and 2) blisters on toes. The assessment was that the pain etiology was unclear. The plan was to request dental see her and obtain a KUB in the morning. The PCP noted that if the symptoms persisted it might be necessary to obtain a CT scan of head. On 6/26/16 at 5:55 p.m., nursing staff documented that the individual was found in bed unresponsive with a blood pressure of 86/70, heart rate 97, and oxygen saturation rates of 98% with a non-rebreathing mask. The individual was transported via emergency medical services (EMS) to the hospital for evaluation. The admitting diagnoses were severe dehydration, aspiration, right mid-lung infiltrate, right upper lobe pneumonia, hypovolemia, and hypernatremia.

On 7/2/16, Individual #294 returned to the Center, and the PCP completed a post-hospital assessment. The assessment was "status post hospital discharge. Will remain in infirmary for closer monitoring times one day. No new orders." This assessment provided no indication of the reason for the one-week hospitalization. On 7/3/16, the PCP conducted another evaluation, and indicated it was for follow-up for the hospital discharge of dehydration. The assessment was "status post hospital discharge. Will observe one more day and if still stable will discharge to home." There was no discussion of aspiration pneumonia or how the individual became so severely dehydrated when Center staff control fluid administration. It was not clear why tachycardia was treated with beta blockers (no EKG was done). It is very likely that tachycardia was a warning sign of developing dehydration and hypovolemia.

- On 4/27/16, Individual #511 was assessed due to fever. Although IPNs were not submitted for the period between 4/20/16 and 4/26/16, documentation showed the individual had a fever several hours prior to the physician's assessment, which was associated with emesis and coughing. The physician noted the individual was hypoxic with an oxygen saturation of 84%, tachycardia, and tachypnea. He was transferred to the ED and was admitted to Intensive Care Unit (ICU) with pneumonia, septic shock, and hypoxemia. On 5/11/16, he returned to the Center. On 5/12/16, the PCP completed an assessment noting the discharge diagnosis of pneumonia. The plan was to continue the post-hospital protocol and repeat a chest x-ray on 5/18/16. The next PCP assessment was not until 5/17/16. On 5/26/16, documentation showed resolution of pneumonia.
- On the night of 2/7/16, Individual #13 was transferred to the ED for evaluation of possible aspiration and was admitted. The admitting diagnosis was bilateral pneumonia, fluid overload, diastolic dysfunction, and pulmonary hypertension. On 2/17/16, he returned to the Center and the PCP saw him. Documentation indicated the hospital records were not available, and the plan was "see orders." On 3/2/16, the results of a Modified Barium Swallow Study (MBSS) were documented. It was not until 3/9/16 that the PCP next documented an assessment, at which time the PCP noted that the acute care plan for UTI could be discontinued. The plan was "see orders."
- On 6/29/16, the PCP documented that Individual #119 was being seen for increasing jerky movements. An exam revealed that he was mildly lethargic and had left periorbital edema secondary to a fall on 6/28/16. The plan was to use cold compresses, check lamotrigine (i.e., seizure medication) level, and obtain labs. Neurological checks twice a day were implemented for seven days. On 6/30/16, the PCP wrote an untimed note documenting the need to transfer the individual to the ED due to "neurological status change." An IPN entry, dated 7/1/16, noted no change in neurological status and a negative computerized tomography (CT) of the head. The assessment was questionable closed head injury, and the plan was to monitor. The PCP did not document a follow-up assessment. The next PCP entry was dated 7/12/16, and it was related to a neurology consult done on 6/23/16 for intractable seizure disorder.
- On 6/6/16, Individual #404's PCP documented that the individual had seizures and "staff is wondering about constipation." The abdominal exam was benign, however, no rectal exam was done, and the plan was to obtain a film of the kidneys, ureters, and bladder (KUB) in the morning. Four days later, on 6/10/16, the next PCP entry documented that the individual had a seizure and a history of constipation. The plan was to check labs and obtain a KUB to follow-up on constipation. On 6/15/16, a post seizure evaluation was documented. The plan was to check labs, KUB, and chest x-ray. On 6/17/16, the PCP documented a history of seizures and constipation. It was noted that labs were "reviewed." The only plan was for the individual to have her headrest adjusted. On 6/18/16 at 1:00 p.m., the PCP noted additional breakthrough seizures, meal refusals, and constipation. Labs were documented as normal. The plan was to monitor blood glucose, repeat labs, and KUB on Monday. At 2:00 p.m., the PCP documented the individual was being transferred to the ED due to bradycardia and lethargy. On 6/19/16, the PCP

documented a post-ED assessment and noted that cardiology and neurology consults were ordered and vital signs would be monitored. On 6/20/16, documentation showed consults were pending and the bowel regimen was modified. This was the first documentation since 6/6/16 that a change was made in the plan to address worsening constipation. The PCP did not document the findings of any of the multiple KUBs that were documented as having been ordered. On 6/22/16, another PCP documented follow-up noting that the Miralax was discontinued, because the individual could not drink eight ounces of fluid. On 6/23/16, a post-Infirmary assessment was documented.

- On 3/7/16, nursing staff documented that Individual #294 had swelling to the left hand. Nursing staff made ten attempts to contact the PCP, but were unsuccessful. At 2:30 p.m., the APRN was notified, and gave an order to transfer the individual to the ED for evaluation. On 3/8/16, the PCP documented that the individual was sent to the ED for x-rays of the left-hand. The ED initially reported that the x-ray was negative for fracture. However, the official radiology interpretation was fracture at the base of the fourth proximal band. The PCP's physical exam noted only the hand was swollen and purple. Neurovascular status was not documented. The plan was to refer the individual to an orthopedic hand specialist. The physical exam also showed that the left lateral foot had two small superficial abrasions. The PCP did not document any follow-up related to the hand fracture or the orthopedic surgeon's assessment. The next PCP IPN entry was dated 3/18/16, and was related to an evaluation for a "fever blister."

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

Summary: Given that during the last review and during this review, for a number of the consultations reviewed, problems were noted with regard to the PCPs reviewing consultations and indicating agreement or disagreement, doing so in a timely manner, and writing an IPN that includes necessary components, all of these indicators will remain in active oversight. The Center also needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs, including the clinical justification for their decisions.

Individuals:

#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	83% 15/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/2	0/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	78% 14/18	1/2	2/2	2/2	2/2	2/2	2/2	2/2	1/2	0/2
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.	72% 13/18	2/2	1/2	2/2	2/2	2/2	2/2	2/2	0/2	0/2
d.	If PCP agrees with consultation recommendation(s), there is evidence	100%	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1	N/A

	it was ordered.	15/15									
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	40% 2/5	1/2	1/1	N/A	N/A	N/A	N/A	N/A	0/2	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #145 for genetics on 2/4/16, and hematology/oncology on 3/7/16; Individual #511 for eye on 6/21/16, and gastroenterology (GI) on 2/1/16; Individual #13 for cardiology on 5/11/16, and urology on 5/10/16; Individual #401 for neurology on 6/23/16, and cardiology on 4/27/16; Individual #592 for ear, nose, and throat (ENT) on 4/16/16, and cardiology on 6/22/16; Individual #240 for neurology on 3/9/16, and GI of 5/9/16; Individual #119 for GI on 5/9/16, and urology on 5/25/16; Individual #404 for neurology on 6/23/16, and cardiology on 6/20/16; and Individual #294 for ENT on 7/7/16, and neurology on 5/11/16.

a. and b. For a number of consultations reviewed, PCPs reviewed and initialed the consultation reports, and indicated agreement or disagreement with the recommendations. The exceptions were the consultations for Individual #404 for neurology on 6/23/16, and Individual #294 for ENT on 7/7/16, and neurology on 5/11/16. For the consultation for Individual #145 for genetics on 2/4/16, the PCP did not complete the review until 3/9/16.

c. Instead of summarizing the results of the consultations in IPNs, one provider stated: "see full report." This appeared to be limited to the one provider.

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

e. The following problems were noted:

- Individual #145's PCP determined that referral to the IDT was not necessary. However, given the relationship between phenylketonuria (PKU) with elevated phenyalaine levels and the assessment was "untreated PKU," an IDT referral was warranted. The consultation report stated: "55 yo [year-old] with intellectual disability, aggressive and self-injurious behavioral problems, history of seizures and osteopenia secondary to untreated PKU. Phenalanine levels remain generally high in spite of her reportedly being on a protein-restricted diet. These levels are expected to be lower in the brain due to PheBloc. Following a low-protein diet will not reverse intellectual disability but lowering her phenylalanine levels may help with her aggressive [behavior] and SIB. Patients with previously untreated PKU can benefit from a low-Phe diet. For these individuals, the main therapeutic goals are improvement in psychological wellbeing, behavioral difficulties, improved concentration, being more aware of external stimuli as well as improvement in socialization, emotional frustration, tolerance and mood."
- For Individual #404, the recommendation from cardiology was: "Bradycardia, unspecified. Asymptomatic, repeat HR [heart rate] 53 and sat [oxygen saturation] 98%. Feb TSH [thyroid stimulating hormone] was normal. Topamax can rarely cause bradycardia. Consider to discuss with neurologist about Topamax and repeat TSH. To discuss with family whether they want any interventions if symptomatic. Consider scopolamine patch for symptomatic bradycardia. There is no immediate treatment needed for HR 47-53." The PCP summarized the consult in the IPN as: "Bradycardia unspecified. No treatment needed for HR 47-53. RTC prn." There was no documentation of the full recommendations of the cardiologist, particularly the potential need to discuss Topamax use with neurology. There was no IDT referral, which was warranted. The medication profile documented

that scopolamine was prescribed, but the consultant's recommendation was not addressed in the PCP summary.

In addition, no IPN was found to address Individual #404's neurology consult on 6/23/16. The PCP noted in the post-Infirmary assessment that the neurology saw the individual and medications were being adjusted. The neurology consult did not address the concerns of the cardiologist relative to bradycardia and Topamax.

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

Summary: The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
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.	39% 7/18	2/2	0/2	0/2	0/2	1/2	0/2	2/2	1/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #145 – osteoporosis, and constipation/bowel obstruction; Individual #511 – osteoporosis, and cardiac disease; Individual #13 – GI problems, and cardiac disease; Individual #401 – GI problems, and cardiac disease; Individual #592 – osteoporosis, and cardiac disease; Individual #240 – GI problems, and seizures; Individual #119 – cardiac disease, and seizures; Individual #404 – osteoporosis, and other: hypothyroidism; and Individual #294 – GI problems, and aspiration).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #145 – osteoporosis, and constipation/bowel obstruction; Individual #592 – osteoporosis; Individual #119 – cardiac disease, and seizures; Individual #404 – other: hypothyroidism; and Individual #294 – GI problems. The following provide a few examples of concerns noted regarding medical assessment, tests, and evaluations:

- For Individual #511, on 4/26/16, a DEXA scan showed osteoporosis with progression noted since 2015. There was no specific plan to address the progression noted. There was no referral to endocrinology for evaluation of progressive osteoporosis.
- In an IPN on 4/7/16, the PCP documented that Individual #13 had an abnormal colonoscopy with the pathology report showing a tubular adenoma and areas of severe dysplasia. The recommendation was to have a follow-up colonoscopy in three years. However, there was no documentation that this was done. The PCP documented the plan as "see orders." According to the IRRF, follow-up was requested more than three years after it was due.
- In addition, for Individual #13, the annual medical assessment included the problem of hyperlipidemia/ atherosclerotic cardiovascular disease (ASCVD) prevention. The plan stated: "currently receiving simvastatin 20 mg. He has routine and prn [as-needed] lab work performed. The last lipid panel had results being normal. The medication has been effective. The only

known possible side effect he exhibits is occasional pruritus. We will continue to monitor this condition." Additionally, on 5/11/16, the cardiologist documented that the individual had the diagnosis of heart failure with preserved ejection fraction (HFpEF). This diagnosis was not listed in the July 2016 AMA, and, therefore, there was no plan. The IRRF documented the diagnosis of diastolic heart failure, although the current nomenclature is HFpEF. Based on the 10-year ASCVD risk documented in the QDRR, this individual was a candidate for moderate to high intensity statin therapy. The AMA did not discuss this and did not set a reduction goal based on the American Heart Association (AHA) guidelines.

- Individual #592's IDT rated him at low risk for cardiac disease. However, he had a history of hyperlipidemia with markedly elevated triglycerides up to 637. The PCP made multiple changes in treatment, but the triglycerides levels remained elevated. The annual medical assessment goal was to "maintain normal lipid values." Although the PCP did make referrals to the clinical pharmacist several times for recommendations, the PCP had not referred Individual #592 to endocrinology for further evaluation.
- On 3/9/16, Individual #240's had a neurological consultation. The report indicated: "I am told he has no seizures for almost 10 years now. He is on carbidopa-levodopa for parkinsons [sic]. A longstanding history of localization related epilepsy better controlled on 2 meds. I wonder if parkinsons [sic] is drug induced. I would just maintain him on current medications." The consult was brief (nine lines in total), and did not specify the cause of the localization-related epilepsy, nor did it include issues related to seizure management, such as labs associated with drug-use, side-effect monitoring, results of last electroencephalogram (EEG), etc. The annual medical assessment did not address the etiology of epilepsy simply noting: "history of seizure disorder with no seizures in more than 10 years." The use of two anti-epileptic drugs in an individual should be clearly justified.
- For Individual #404, a DEXA scan showed a decrease in BMD. Although the PCP noted the BMD scores in the quarterly medical summaries, there was no discussion of how the decrease would be addressed.
- Individual #294's annual medical assessment addressed dysphagia and GERD but did not specifically address other issues related to aspiration. Issues related to aspiration that the PCP should have addressed included:
    - Achieving optimal management of dysphagia via positioning, proper diet texture, etc.;
    - Maintenance of good oral hygiene;
    - Absence of untreated dental decay;
    - Maintenance of adequate nutritional status (surrogate indicators include lab evidence, such as albumin/pre-albumin)
    - Optimal management of drugs (those that increase anti-cholinergic burden, sedating medications, and those that cause xerostomia);
    - Maintenance of adequate hydration (based on physical assessment and labs);
    - Increasing mobility; and
    - Adequate control of chronic respiratory conditions (physical exam, pulse oximetry, pulmonary function test).

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.	
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs.	Individuals:

#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	44% 8/18	2/2	1/2	0/2	0/2	1/2	0/2	2/2	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. However, those action steps assigned to the PCPs that were identified for the individuals reviewed that were implemented were for Individual #145 – osteoporosis, and constipation/bowel obstruction; Individual #511 – cardiac disease; Individual #592 – osteoporosis; Individual #119 – cardiac disease, and seizures; Individual #404 – other: hypothyroidism; and Individual #294 – GI problems.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: The Center's performance on these indicators varied over the last two reviews and this review. Although it was good to see some improvement with some of the indicators, all of them will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	QDRRs are completed quarterly by the pharmacist.	83% 15/18	1/2	2/2	2/2	2/2	1/2	2/2	1/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the										

	QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	28% 5/18	0/2	1/2	1/2	0/2	2/2	0/2	0/2	1/2	0/2
	ii. Benzodiazepine use;	100% 7/7	N/A	2/2	N/A	2/2	N/A	N/A	1/1	N/A	2/2
	iii. Medication polypharmacy;	100% 4/4	N/A	2/2	N/A	2/2	N/A	N/A	N/A	N/A	N/A
	iv. New generation antipsychotic use; and	83% 10/12	2/2	0/2	N/A	2/2	2/2	2/2	2/2	N/A	N/A
	v. Anticholinergic burden.	100% 14/14	2/2	2/2	2/2	2/2	2/2	2/2	N/A	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.	94% 17/18	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	94% 15/16	2/2	2/2	2/2	2/2	2/2	2/2	2/2	N/A	1/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 10/10	1/1	2/2	1/1	1/1	2/2	2/2	1/1	2/2	N/A
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: a. In addition to QDRRs for three individuals not including signature dates, they were overdue, because all three were dated February 2016, but the previous QDRRs were completed in August 2015.

b. For Individual #511, the QDRRs identified at least three criteria for metabolic syndrome, but the Pharmacist did not make recommendations for further review.

Numerous problems continued with regard to the Pharmacy Department's review of labs and/or diagnostics. For example, at times, the Pharmacy Department left the lab/diagnostics section blank; did not address labs needed for specific drugs (e.g., eye exams for Seroquel); and/or did not further review abnormal lab results to determine significance followed by recommendations, if clinically appropriate. For example, on page 4 for Individual #145, there was a chart that included items such as DEXA, EKG and Eye Exam. There was no information included here and all were applicable for this individual based on the lab matrix.

Of particular concern, in the 2/18/16 QDRR, the Clinical Pharmacist noted that Individual#240 had "some symptoms noted that indicate a GI bleed." The recommendation was to increase the dose of the PPI. However, it would not be appropriate to manage a suspected GI bleed simply by increasing the dose of the PPI. Gastrointestinal bleeding has the potential to be a life threatening condition and clinical management must include identification of the source of bleeding. On 5/16/16, Individual #240's serum ferritin was level was 1620. The clinical pharmacist made the recommendation to discontinue a multivitamin. There was no discussion related to the possible etiology of this markedly elevated serum ferritin.

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

One concern noted was for Individual #401. The Clinical Pharmacist recommended discontinuing statins due to the individual's ASCVD risk being less than 5%. However, this score appeared to have been based on the use of treated cholesterol values. The PCP discontinued statin. The lipid panel was last checked on 2/24/16, and there had been no recommendation to repeat following the discontinuation of the statin.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/7	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% 0/7	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% 0/7	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% 0/7	0/1	0/1		0/1	0/1	0/1	0/1		0/1
Comments: a. and b. Individual #13 and Individual #404 were at low risk for dental. For two individuals with low risk ratings for dental, the IDTs had not provided sufficient justification for the risk rating (i.e., Individual #294) or not modifying the risk rating upon											

change of status (i.e., Individual #592). The IDTs of some individuals rated them at medium or high risk, but did not include dental goals in their IHCPs (i.e., Individual #145, Individual #240, and Individual #119). For the remaining individuals, none had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. In addition to the IDTs of individuals at medium and high risk for dental not developing clinically relevant, achievable, and measurable goals/objectives, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For these seven individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services. Individual #404 was in the core group, so a complete review was completed for her. For Individual #13, who was at low risk for dental and who was in the outcome sample, the "deep review" items were not scored, but other items were scored.

Outcome 4 – Individuals maintain optimal oral hygiene.

Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	Individuals have no diagnosed or untreated dental caries.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	N/A									
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	50% 2/4	0/1	N/R	N/R	N/A	0/1	1/1	1/1	N/R	N/R
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: b. When individuals' exams identified them as having periodontal disease, but no periodontal charting was available, the Monitoring Team could not rate this indicator (e.g., Individual #511, Individual #13, Individual #404, and Individual #294). The Monitoring Team is applying the "N/R" score to this round of reviews to allow State Office to work with the Centers to improve practice. However, beginning in the next round of reviews, if an individual should have had periodontal charting, and it is not completed, and a justification is not provided for a lack of periodontal charting, then this indicator will be scored 0.

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

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: The Center's scores have varied on these indicators. They will continue under active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	56% 5/9	1/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	56% 5/9	1/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	N/A									
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	71% 5/7	1/1	0/1	N/A	N/A	1/1	0/1	1/1	1/1	1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									
Comments: a. None.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
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: a. through c. Based on the documentation provided, in the six months prior to the review, none of the individuals reviewed experienced dental emergencies.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: During this review and the last two reviews, the Center's scores have varied on these indicators. IDTs need to focus on ensuring measurable plans/strategies are included in the IHCPs of individuals who would benefit from suction tooth brushing, and QIDPs summarize related data in monthly reviews. In addition, assigned staff should regularly conduct monitoring of suction tooth brushing.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	33% 1/3	N/A	0/1	N/R	N/A	N/A	0/1	N/A	N/A	1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	33% 1/3		0/1				0/1			1/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3		0/1				0/1			0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/3		0/1				0/1			0/1
Comments: a. Although it appeared that Individual #511 and Individual #240 received suction tooth brushing, their IHCPs did not include a related action steps/plans.											

Outcome 9 – Individuals who need them have dentures.											
Summary: The Dental Department improved its performance with regard to assessing individuals with missing teeth to determine the appropriateness of dentures, including providing clinically justified recommendations. Efforts should be made to sustain this improvement.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 6/6	1/1	N/A	1/1	N/A	N/A	1/1	1/1	1/1	1/1

b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained an area on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	20% 2/10	N/A	0/1	1/1	0/2	N/A	0/2	0/1	0/1	1/2
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.	44% 4/9		0/1	1/1	0/2		0/2	1/1	1/1	1/1
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/4		0/1	N/A	0/2		0/1	N/A	N/A	N/A
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/6		N/A	0/1	N/A		0/1	0/1	0/1	0/2
e.	The individual has an acute care plan that meets his/her needs.	0% 0/10		0/1	0/1	0/2		0/2	0/1	0/1	0/2
f.	The individual's acute care plan is implemented.	0% 0/10		0/1	0/1	0/2		0/2	0/1	0/1	0/2
Comments: The Monitoring Team reviewed 10 acute illnesses and/or acute occurrences for seven individuals, including Individual #511 – bilateral conjunctivitis on 3/1/16; Individual #13 – possible aspiration pneumonia on 2/7/16; Individual #401 – laceration of											

right eyebrow with mild head injury on 4/13/16, and puncture wound to right heel with cellulitis on 4/29/16; Individual #240 – chemical dermatitis on 2/12/16, and aspiration pneumonia, and hypothermia on 5/31/16; Individual #119 – laceration to left eyebrow; Individual #404 – bradycardia, and hypothermia on 6/18/16; and Individual #294 – fracture of left hand on 3/7/16, and unresponsive with possible seizure, dehydration, and pneumonia on 6/26/16 .

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the DADS SSLC nursing guideline entitled: "When contacting the PCP" were: Individual #13 – possible aspiration pneumonia on 2/7/16, Individual #119 – laceration to left eyebrow, Individual #404 – bradycardia, and hypothermia on 6/18/16, and Individual #294 – fracture of left hand on 3/7/16. For Individual #294, the incident on 6/26/16 during which she unresponsive with possible seizure, dehydration, and pneumonia was a 911 emergency.

e. Common problems with the acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing protocols; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur.

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

- Upon initial assessment, nursing staff provided the following description of Individual #511's eye: "(R) upper eyelid is swollen with yellowish/green drainage. [Individual] is able to open eye about half way due to the large amount of swelling. (L) Lower lid is swollen yellow/greenish drainage noted, facial swelling." Given this description, the nurse should have, but did not place him on contact precautions. Nursing staff also did not develop and implement an acute care plan. Follow-up nursing assessments did not consistently describe whether or not the symptoms of drainage, and/or swelling were improving. Ongoing nursing IPNs did not include nursing interventions related to infection control practices, or notification to the Infection Control Preventionist.
- For Individual #401, on 4/29/16, nursing staff tried to dislodge what appeared to be glass in the puncture wound site on her heel. The Monitoring Team member discussed this issue with the Chief Nurse Executive (CNE) during the onsite review, because nursing staff should not attempt to dislodge or manipulate objects in wounds. Documentation was not presented to show that nursing staff conducted an assessment or noted review of Individual #401's immunization record for a current Tetanus immunization. Follow-up nursing assessments did not consistently describe whether or not the symptoms of drainage, and/or swelling were improving.
- For Individual #240, prior to the 2/12/16 PCP order and diagnosis of "chemical dermatitis," no nursing assessments were found in IPNs. It was not until 2/16/16, that the next IPN was completed. After 2/16/16, follow-up nursing assessments did not consistently describe the location, size (i.e., increasing or decreasing), drainage, or odor of the wound, or response to the treatment plan. Nursing staff did not develop an acute care plan.
- According to a late nursing entry, dated 5/25/16 at 11:00 p.m. for 5/25/16 at 1:40 p.m., Individual #240 was symptomatic with "grunting on respiration with coarse bilateral lung sounds." The next nursing assessment was documented on 5/25/16 at 11:45 p.m. Based on his signs and symptoms and his documented risk for aspiration and respiratory compromise, nursing staff should have assessed him more frequently. The late entry did not indicate whether or not the nurse notified the physician. However, on 5/25/16, a medical IPN indicated a provider completed a medical assessment. On 5/31/16, both nursing and

medical IPNs documented assessment of the acute issue. Individual #240 was sent to the hospital via 911.

Upon the individual's return from the hospital, on 6/17/16 at 4:18 p.m., an assessment noted no skin tears to the buttocks. However, several hours later, on 6/18/16 at 1:00 a.m., notes indicated "red open excoriated area to inner coccyx." Nursing staff did not document measurements, nor did the note indicate if the area was on the left or right coccyx. The 6/18/16 10:00 a.m. nursing IPN denoted: "new area of breakdown in left gluteal fold, Stage II." It could not be discerned if the 10:00 a.m. note was addressing the same area as the 1:00 a.m. note. No documentation was presented to show nursing staff reported the Stage II decubitus to the physician, nor did the 6/18/16 medical IPN include any reported assessment of the Stage II decubitus. Nursing staff did not address the skin integrity issue in the acute care plan, and overall, the acute care plan did not meet Individual #240's needs with regard to the respiratory issues.

- On 3/7/16, for Individual #294's possible fracture of her left hand, nursing staff documented 10 attempts to call the physician. When this was unsuccessful, the nurse indicated she contacted another provider. No acute care plan was developed.
- Between 6/20/16 and 6/26/16, Individual #294 received a number of prescribed PRN medications for pain. Nursing staff should have developed an acute care plan for pain, but did not. Moreover, nursing staff did not document completion of nursing assessments that considered the cumulative effects of her regularly prescribed medications along with the pain medication, such as consistently observing her level of consciousness, and increasing the frequency of vital signs. Although nursing staff often documented the individual's response to the medication as "effective," they generally did not provide a description of what this meant. Individual #294's IDT had previously identified her as being at high risk for respiratory compromise. A nursing IPN, dated 6/26/16 at 6:30 p.m., indicated the individual was unresponsive, staff moved her to the floor to start cardiopulmonary resuscitation (CPR), administered oxygen, and called 911. Emergency Medical Staff (EMS) arrived to transport her to the hospital.

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

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

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
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.	22% 4/18	0/2	1/2	0/2	1/2	0/2	1/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #145 – choking, and dental; Individual #511 – constipation/bowel obstruction, and circulatory; Individual # – aspiration, and cardiac disease; Individual #401 – GI problems, and skin integrity; Individual #592 – GI problems, and weight; Individual #240 – respiratory compromise, and GI problems; Individual #119 – constipation/bowel obstruction, and seizures; Individual #404 – constipation/bowel obstruction, and circulatory; and Individual #294 – infections, and other: pain).

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 #511 – constipation/bowel obstruction, Individual #401 – GI problems, Individual #240 – respiratory compromise, and Individual #404 – circulatory.

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

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

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

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/17	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/17	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs 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 generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

Outcome 6 – Individuals receive medications prescribed in a safe manner.

Summary: For the two previous reviews, as well as this review, the Center did well with the indicators related to administering medications according to the nine rights (c), and nurses following infection control practices (g, and previously f). However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review them until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. All of these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
a.	Individual receives prescribed medications in accordance with applicable standards of care.	57% 8/14	1/2	1/2	2/2	0/1	1/1	0/1	2/2	0/1	1/2
b.	Medications that are not administered or the individual does not accept are explained.	50% 4/8	1/2	0/1	N/A	1/1	N/A	0/1	1/1	1/1	0/1
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% 5/5	1/1	1/1	1/1	N/A	N/A	N/A	1/1	N/A	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/R									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds	N/R									

	before and after medication administration, which the IHCP or acute care plan should define.										
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
f.	Individual's PNMP plan is followed during medication administration.	100% 5/5	1/1	1/1	1/1	N/A	N/A	N/A	1/1	N/A	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	80% 4/5	1/1	0/1	1/1	N/A	N/A	N/A	1/1	N/A	1/1
h.	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
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/6	0/1	0/1	N/A	0/1	N/A	0/1	N/A	0/1	0/1
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	50% 1/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	1/1	N/A

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of five individuals, including Individual #145, Individual #511, Individual #13, Individual #401 (two unsuccessful attempts were made), Individual #592 (medication time made observation challenging), Individual #240 (deceased so no observation), Individual #119, Individual #404 (hospitalized, so no observation), and Individual #294.

Of note, due to problems with the IRIS (i.e., electronic health record) system's ability to produce documentation in an easily digestible format, the Monitoring Team conducted a limited review of documentation of medication administration. Specifically, documentation for the months of June and July was available in hand-written format, so it was used for this review. Due to Individual #240's death in June 2016, the months of May and June were reviewed for him.

a. and b. Problems noted included:

- MARs for Individual #145, Individual #511, Individual #401, Individual #240, and Individual #294 showed omissions and/or MAR blanks.
- For Individual #404, orders were not carried out for Lasix and Potassium as prescribed on 7/5/16.

- For Individual #294, a number of circled medication blanks were not explained.

c. Individual #145 was exhibiting challenging behaviors during the medication observation. The nurse administering medications did a nice job of working with the individual to facilitate medication administration.

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. This indicator was not assessed during this review, but will be during upcoming reviews. State Office is working with the Centers to comply with these requirements.

e. At times, nursing staff did not document the reason, route, and/or the individual's reaction or the effectiveness of the PRN or STAT medication.

f. During onsite observations, it was positive that nursing staff followed the PNMPs for five individuals.

- For Individual #145, Habilitation Therapies staff should review the PNMP, and observe a medication pass. Currently, nurses are giving her nine pills at a time. Given that the IDT rated her at medium risk for choking, a review is necessary to determine whether or not there should be any additions to the Medication Administration section of the PNMP.

g. With one exception, for the individuals observed, nursing staff followed infection control practices. The exception was for Individual #511 for whom the tip of gastrostomy tube (G-Tube) touched the individual's shirt when re-connecting, and the nurse did not rinse the syringe prior to putting it back in a plastic wrapper in the individual's backpack.

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

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

j. and k. For the individuals reviewed, Center staff did not identify any possible ADRs.

l. The problems related to documentation of medication variances varied, but some examples included:

- Many MAR blanks were not reconciled and reported;
- Some medication variance forms did not indicate that the physician was notified;
- Frequently, follow-up was identified as notification of the Nurse Manager, which often was not adequate; and
- For Individual #404, on 7/9/16 at 12:00 p.m., a variance was discovered, which occurred on 7/5/16. The variance was a failure to implement physician orders for Lasix, and Potassium. Nurses reportedly conduct 24-hour chart checks, so it is unclear why this was not discovered within the 24-hour period. In addition, conflicting information was found on the Medication Variance Report that classified the variance using the Medication Severity Index as an F, which requires the unusual

incident process to be initiated, but on the Medication Variance form, it was marked as Category C.

m. On 7/7/16, nursing staff administered the wrong medications to Individual #240, including Dilantin, Baclofen, Lamotrigine, and Metoclopramide. No nursing IPNs were found to show ongoing assessments/observations for adverse drug reactions or untoward changes.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Improvement was still needed with regard to IDTs referring individuals meeting referral criteria to the PNMT or the PNMT making self-referrals. Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/11	0/1	0/1	0/1	0/2	0/2	N/A	N/A	0/2	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/11	0/1	0/1	0/1	0/2	0/2			0/2	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/11	0/1	0/1	0/1	0/2	0/2			0/2	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/11	0/1	0/1	0/1	0/2	0/2			0/2	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/11	0/1	0/1	0/1	0/2	0/2			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;	71% 5/7	1/1	0/1	0/1	N/A	N/A	2/2	2/2	N/A	N/A
	ii. Individual has a specific goal/objective that is clinically	0%	0/1	0/1	0/1			0/2	0/2		

		relevant and achievable to measure the efficacy of interventions;	0/7									
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	0% 0/7	0/1	0/1	0/1			0/2	0/2		
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/7	0/1	0/1	0/1			0/2	0/2		
	v.	Individual has made progress on his/her goal/objective; and	0% 0/7	0/1	0/1	0/1			0/2	0/2		
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1			0/2	0/2		

Comments: The Monitoring Team reviewed 11 goals/objectives and/or need areas related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: choking for Individual #145; falls for Individual #511; falls for Individual #13; choking, and falls for Individual #401; choking, and falls for Individual #592; aspiration, and fractures for Individual #404; and aspiration, and fractures for Individual #294.

a.i. and a.ii. None of the IHCPs included clinically relevant, achievable, and measurable goals/objectives. In some cases, because IDTs had incorrectly assigned low risk ratings to individuals with higher levels of risk, no goal/objective or action plan was developed and/or implemented (e.g., choking for Individual #592, falls for Individual #401).

b.i. The Monitoring Team reviewed seven areas of need for five individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: falls for Individual #401; aspiration for Individual #511; aspiration for Individual #13; aspiration, and GI problems for Individual #240; and GI problems, and falls for Individual #119.

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

- According to the most recent PNMT assessment, on 1/20/16, Individual #511's initial diagnosis of bronchitis was changed to aspiration pneumonia. However, he was not referred to the PNMT at that time. On 4/27/16, he experienced another episode of aspiration pneumonia.
- On 2/2/16, Individual #13 had aspiration pneumonia. His IDT did not refer him to the PNMT, and the PNMT did not initiate a self-referral.

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

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, 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, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full

reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.

Summary: These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
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.	6% 1/17	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2	1/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/11	0/1	0/1	0/2	N/A	0/1	0/2	0/2	N/A	0/2
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% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCP for which documentation was found to confirm the implementation of the PNM action steps that were included was for fractures for Individual #294. Often completion of existing action steps could not be measured, because they were not measurable (e.g., "ongoing," or the date of the next year's ISP).

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

- In July 2016, Individual #145 fell 10 times, but documentation was not presented to show her IDT referred her to the PNMT.
- In February 2016, Individual #592 fell four times, but it did not appear the IDT reviewed this series of falls.
- In March 2016, Individual #294 fractured her hand, but it was not until 4/14/16 that the IDT took action to cover the spokes of her wheelchair.

c. On 8/5/16, Individual #145's IDT held an ISPA meeting after the PNMT completed a review, and the PNMT OT attended the meeting. However, the ISPA stated that the PNMT review was due on 8/2/16, as though it had not been completed. The documentation provided no evidence that the IDT revised the individual's IHCP for falls, but rather only that the IDT increased the risk level for falls. The IDT/PNMT did not document discussion of the need to change Individual #145's risk level for medication side effects despite the PNMT identifying side effects of Valium as the etiology behind the increase in falls with six prior to 6/1/16 that year, and nine additional falls over June and July 2016. In fact, the ISPA provided no real clear discussion of the PNMT review findings or recommendations.

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

Summary: Compliance with PNMP implementation showed an 8% reduction from the last review. This continues to be an area in which focused efforts are needed,

because PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	68% 39/57
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.	62% 8/13
Comments: a. The Monitoring Team conducted 57 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 17 out of 25 observations (68%). Staff followed individuals' dining plans during 20 out of 29 mealtime observations (69%). Transfers were completed correctly two out of three times (67%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: The Center had not made progress on this indicator.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
Comments: a. As noted above, Individual #294's OT/PT assessment recommended an updated MBSS, but no evidence was presented to show this occurred.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: IDTs did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant	0%	0/1	0/1	0/1	0/2	N/A	0/1	0/1	0/1	0/1

	and achievable to measure the efficacy of interventions.	0/9									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/9	0/1	0/1	0/1	0/2		0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/9	0/1	0/1	0/1	0/2		0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/9	0/1	0/1	0/1	0/2		0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/2		0/1	0/1	0/1	0/1

Comments: a. and b. Individual #592 had functional motor and self-help skills, so a goal/objective was not indicated. For some individuals that had OT/PT needs and/or had regressed, OT/PT assessments provided no rationale for not providing OT/PT services (e.g., Individual #511, Individual #13, Individual #240 – no OT/PT assessment submitted, and Individual #119). For the remaining individuals, the goals/objectives were not clinically relevant and achievable (i.e., based on assessment results), as well as measurable, and/or IDTs had not incorporated them into ISP/ISPA action plans.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. 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.

Individual #592 was part of the core group, and so the Monitoring Team did not review the "deeper review" items for him. For the remaining eight individuals, full reviews were conducted due to a lack of clinically relevant, achievable, and measurable goals/objectives to address areas of OT/PT need, and/or because integrated ISP progress reports did not provide an analysis of related data, or as noted above, had not met to address lack of progress.

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

Summary: It was good to see an IDT had met to terminate an OT/PT service, when appropriate. However, the Center should work on ensuring measurable strategies and actions plans for OT/PT supports are implemented. The Monitoring Team will continue to review these indicators.

#	Indicator	Overall Score	Individuals: 145	511	13	401	592	240	119	404	294
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	1/1	N/A	N/A	N/A	N/R	N/A	N/A	0/1	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP	100% 1/1	1/1	N/A	N/A	N/A		N/A	N/A	N/A	N/A

	meeting, then an ISPA meeting is held to discuss and approve the change.										
Comments: a. Some examples of the problems noted included: • No plans submitted for the agree-upon SAPs. • Lack of evidence in integrated ISP reviews that supports were implemented.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given that over the last two review periods and during this review, individuals observed generally had clean adaptive equipment (Round 9 – 94%, Round 10 – 100%, and Round 11 - 100%) that was in working order (Round 9 – 91%, Round 10 – 96%, and Round 11 - 87%), Indicators a and b will move to the category of requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's scores (Round 9 – 76%, Round 10 – 70%, and Round 11 - 78%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	402	388	321	573	546	441	185	108	129
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 23/23	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.	87% 20/23	0/1	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.	78% 18/23	0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		551	271	511	250	120	353	294	545	27
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	0/1	1/1	1/1	1/1	1/1	1/1	1/1

		Individuals:									
#	Indicator		287	306	361	1					
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	2/2	1/1	1/1					
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/2	1/1	0/1					
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	2/2	1/1	0/1					

Comments: a. The Monitoring Team conducted observations of 23 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see.

b. It was positive that the equipment observed generally was in working order. The exceptions were Individual #402's wheelchair, whose headrest fell off while the Monitoring Team was conducting the observation, resulting in the individual's head dropping backwards; Individual #1's headrest was not in the proper position; and Individual #306's left brake on his wheelchair did not work properly.

c. Based on observation of Individual #402, Individual #388, Individual #321, Individual #511, and Individual #1 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. One of the indicators had sustained high performance scores to be moved the category of requiring less oversight.

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

Given that most ISP personal goals did not meet criterion with ISP indicators 1-3, the determination of progress was not possible to determine. The goals that were developed and did meet criteria did not have data to allow progress to be assessed (with one exception).

Action steps in the ISP were not consistently implemented.

Attending to the status of SAPs is a focus area for Lufkin SSLC. Much work is needed here in design, implementation, and review.

The Monitoring Team found only individual consistently engaged in activities. Levels of engagement observed at day program 510 varied from day to day. Data presented at the monthly QAQI Council did not accurately portray the level of engagement at the facility.

Many individuals at Lufkin SSLC attended public school and/or received public school educational services at the on-campus classroom. The facility had an excellent working relationship with the local school district. It was something that they had fostered over a number of years.

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

Center staff should focus on ensuring individuals' AAC/EC devices are available in all appropriate settings, individuals use them functionally, and staff are competent in the use of the devices in relevant contexts and settings. In addition, IDTs did not have a way to measure clinically relevant outcomes with regard to individuals' communication skills.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that goals were not yet individualized and did not meet criterion with ISP indicators 1-3, the indicators of this outcome also did not meet criteria. The goals that were developed did not have data to allow progress to be assessed (with one exception). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	145	401	97	259	511	294			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
Comments: Once 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. 4-7. Overall, personal goals did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans. For the personal goals that met criterion, there was no evidence that progress was being made because reliable and valid data were not available for all but one goal (Individual #511), and for this one goal, progress was not evident due to lack of data being recorded and lack of implementation.										

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: Performance on both of these indicators decreased since the last review. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	145	401	97	259	511	294			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
40	Action steps in the ISP were consistently implemented.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									

Comments:
39. Staff were generally able to describe supports and risks included in the ISP. It was not possible, however, to confirm that staff were competent to implement their ISPs due to the overall lack of data supporting implementation. The exception was Individual #294, for whom staff were observed implementing her work/day program as described.

40. Action steps were not consistently implemented for any individuals as documented above.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Attending to the status of SAPs is a focus area for Lufkin SSLC. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
6	The individual is progressing on his/her SAPS	12% 3/25	2/3	1/3	0/3	0/3	0/3	0/3	0/3	0/2	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	43% 3/7	0/2	0/1	N/A	N/A	0/1	2/2	N/A	N/A	1/1
8	If the individual was not making progress, actions were taken.	0% 0/12	N/A	0/1	0/3	0/3	0/2	N/A	N/A	0/2	0/1
9	Decisions to continue, discontinue, or modify SAPs were data based.	29% 6/21	1/3	1/3	1/3	0/3	0/3	2/2	N/A	0/2	1/2

Comments:
6. Individual #145's write name, and Individual #65's state the side effects of medications and state healthy foods SAPs were rated as progressing. Several SAPs (e.g., Individual #401's count money SAP) were not progressing. Some SAPs did not have sufficient data to determine progress (e.g., Individual #3's identify traffic signs SAP) and were scored as not progressing because they did not have measurable objectives, were not meaningful/functional, and/or did not have reliable data. Finally, some SAPs' data did indicate progress (e.g., Individual #97's play ball SAP), but were scored as not making progress because they did not have measurable objectives, were not meaningful/functional, and/or did not have reliable data.

7-9. Seven SAP objectives were reported by the facility to be achieved, three of which had a new objective established (i.e., Individual #210's wash arms and neck SAP, and Individual #259's state the side effects of medicines, and his state appropriate actions SAPs). Four other SAPs (i.e., Individual #97's play ball SAP, Individual #145's write name SAP, and Individual #65's state the side effects of medications and state healthy foods SAPs) achieved their objectives, but no new objectives were achieved. Similarly, 12 SAPs were judged as not progressing (e.g., Individual #401's set her alarm clock SAP), 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 appeared to be data

based decisions to continue, discontinue, or modify SAPs in 29% of the SAPs. Improvement of these of data based decisions should be a priority of Lufkin SSLC.

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

Summary: Performance decreased, pointing further evidence of the need for Lufkin SSLC to attend to the quality of SAPs. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 65	145	222	401	97	259	3	124	210
13	The individual's SAPs are complete.	0% 0/25	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/2

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although none of the 25 SAPs were found to be complete, the majority of components were present for the majority of SAPs.

The most common missing component was specific instructions to teach the skill. All of the SAP training sheets indicated that forward chaining or shaping methodologies should be used for training the SAP. None of the SAP training sheets, however, contained explanations of these two training methodologies, and none of the DSPs interviewed could describe the difference. Ensuring that all SAP training sheets have the necessary components should be a priority for Lufkin SSLC.

Outcome 5- SAPs are implemented with integrity.

Summary: SAPs that were observed by the Monitoring Team were not done correctly and the facility had not implemented a plan to regularly assess the quality of implementation. Without correct implementation, learning is not likely to occur and instead, valuable staff and individual personal time are wasted. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 65	145	222	401	97	259	3	124	210
14	SAPs are implemented as written.	0% 0/4	N/A	N/A	0/1	N/A	0/1	0/1	0/1	N/A	N/A
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	20% 5/25	2/3	1/3	1/3	0/3	0/3	0/3	0/3	1/2	0/2

Comments:
14. The Monitoring Team observed the implementation of four SAPs. None were judged to be implemented and documented as written.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. Five SAP integrity measures were documented (Individual #65's state the side effects of medications, and state healthy foods SAPs, Individual #145's write her name SAP, Individual #222's point to pictures SAP, and Individual #124's pour his drink SAP). Lufkin SSLC established a schedule of SAP integrity that would ensure that each SAP was observed at least once every six months. Some of these data were presented in the facility's monthly QAQI Council meeting, however, the data were not accurate and did not correctly portray the status of SAP implementation integrity.

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

Summary: These two indicators received high scores on this review and indicator 16 also had a high score on the previous review. However, given that the indicators related to SAP data and SAP implementation integrity were far from meeting criteria, these two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 65	145	222	401	97	259	3	124	210
16	There is evidence that SAPs are reviewed monthly.	84% 21/25	3/3	3/3	3/3	3/3	3/3	3/3	0/3	1/2	2/2
17	SAP outcomes are graphed.	84% 21/25	3/3	3/3	3/3	3/3	3/3	3/3	0/3	1/2	2/2

Comments:
16. The Monitoring Team was encouraged that the majority of SAPs had a data based review in the QIDP monthly report. Four QIDP reports did not have SAP data (i.e., Individual #124's pour drink SAP, and all three of Individual #3's SAPs).

17. SAP data were consistently graphed.

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

Summary: Engagement in activities was an ongoing area of focus at Lufkin SSLC. Some supports from state office that were occurring at other facility were not yet occurring at Lufkin SSLC. It was good to see that engagement was being measured at the facility, however, problems with the reliability and validity of the data, as well as the establishment of goals also needed to be addressed. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 65	145	222	401	97	259	3	124	210
18	The individual is meaningfully engaged in residential and treatment sites.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1

19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	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 only Individual #259 consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

Levels of engagement observed by the Monitoring Team at day program 510 varied from day to day. That is, on some days there was lots of activity, participation by individuals, and lots of action by direct support professionals (e.g., Thursday morning). On other days, most individuals were not engaged and DSPs were not interacting with them (e.g., Wednesday morning).

19-21. Lufkin SSLC recently began to conduct monthly engagement measures. At the time of the onsite review, the facility was collecting baseline data used to establish individualized engagement goals. Data presented at the monthly QAQI Council did not accurately portray the level of engagement at the facility. Details were reviewed onsite with staff who were taking the lead on managing and supporting higher levels of engagement.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary:			Individuals:								
#	Indicator	Overall Score	65	145	222	401	97	259	3	124	210
22	For the individual, goal frequencies of community recreational activities are established and achieved.	33% 3/9	1/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22-24. There was evidence that all nine of individuals reviewed participated in community outings, however, there were established goals for this activity for only Individual #222, Individual #97, and Individual #65. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved. Lufkin SSLC did provide data concerning the implementation of SAPs in the community, however, there were no established goals for this activity. SAP training data and a goal for

the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goals were achieved.

With the recent (February 2016) creation of community specialists for each unit, an increase in outings and community training were evident to the Monitoring Team. This was good to see. The unit directors played an important role in the development and implementation, and now management, of these positions. Criteria for the indicators in this outcome also require that goals be set, monitored, and achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: Many individuals at Lufkin SSLC attended public school and/or received public school educational services at the on-campus classroom. The facility had an excellent working relationship with the local school district. It was something that they had fostered over a number of years. As a result, the requirements for this indicator were met at this review and had been met for many years. This indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	65	222	259						
25	The student receives educational services that are integrated with the ISP.	100% 3/3	1/1	1/1	1/1						
Comments: 25. Individual #222, Individual #65, and Individual #259 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.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including	0%	0/1			0/1					

	timeframes for completion;	0/2									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2	0/1			0/1					
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2	0/1			0/1					
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2	0/1			0/1					
Comments: None.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	33% 4/12	3/4	0/1	0/1	N/A	1/4	N/A	0/2	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	25% 3/12	3/4	0/1	0/1		0/4		0/2		0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/12	0/4	0/1	0/1		0/4		0/2		0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/12	0/4	0/1	0/1		0/4		0/2		0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/12	0/4	0/1	0/1		0/4		0/2		0/1
Comments: a. and b. Individual #401 communicated verbally and was easily understood. The goals/objectives that were clinically relevant, as well as measurable were Individual #145's goals/objective related to imitating the model, expanding upon single or two word utterances, and using her AAC device to repair communication breakdowns. The SAP for Individual #592 to point to a named picture was clinically relevant, but not measurable. c. through e. The three individuals for whom communication goal development was not applicable were part of the core group, so full reviews were completed for them. For the remaining individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives, and/or a lack of IDT analysis and/or action when progress did not occur.										

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	145	511	13	401	592	240	119	404	294
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	18% 2/11	2/4	N/A	N/A	N/A	0/4	N/A	0/2	N/A	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	20% 1/5	0/4	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Evidence often was not present to show that the strategies were implemented.											

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: Given the low scores from this review, Center staff should focus on ensuring individuals' AAC/EC devices are available in all appropriate settings, individuals use them functionally, and staff are competent in the use of the devices in relevant contexts and settings. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]			Individuals:								
#	Indicator	Overall Score	441	1	68	294	394	545	321		
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	14% 1/7	0/1	0/1	0/1	0/1	0/1	1/1	0/1		
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	14% 1/7	0/1	0/1	0/1	0/1	0/1	1/1	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.	50% 2/4									
Comments: a. and b. It was concerning that often individuals' AAC devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.											

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, all of the staff of the department were new, except for the Admissions and Placement Coordinator. The new staff were just learning their roles, responsibilities, and the requirements of the Settlement Agreement.

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

Overall, there was progress in the way supports were worded in term of measurability and in the comprehensiveness of the list of supports. Even so, similar issues regarding training of provider staff remained since the last review. Continued focus on the comprehensiveness of the list of supports is required.

The facility continued to provide good post move monitoring, though improvements in actions and in documentation are required, especially for the important supports of community provider staff training and their expected resultant knowledge and competencies. This was particularly relevant for one individual who had a number of problems after his transition. The Post Move Monitor position was recently vacated and the position was posted. A PMM had not been hired at the time of the onsite review.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.

Summary: Overall, Lufkin SSLC made progress in improving the way supports were worded in term of measurability and in the comprehensiveness of the list of supports. Similar issues regarding training of provider staff remained since the last review. Continued focus on the comprehensiveness of the list of supports is required as is ensuring that they are worded in a way that the post move monitor and the new community provider can determine if the support was indeed provided. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	197	86							
1	The individual's CLDP contains supports that are measurable.	0%	0/1	0/1							

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

Comments:

Thirteen individuals transitioned from the facility to the community since the last monitoring review. Two were included in this review (Individual #197, Individual #86). Both individuals transitioned to a group home that was part of the State's Home and Community-based Services (HCS) program. Individual #86 was reported to be doing well overall. Individual #197 had experienced several potentially disruptive events and these were ongoing at the time of the monitoring site visit. The Monitoring Team reviewed these two transitions and discussed them in detail with the Lufkin SSLC Admissions and Placement staff while onsite.

1. Many of the supports defined in the CLDPs for Individual #197 and Individual #86 were measurable, but many important supports were not measurable. Individual #197 had 14 pre-move supports and 42 post-move supports, while Individual #86 had 12 pre-move supports and 34 post-move supports. Supports for the individual need to be worded in a way that the post move monitor (and the provider) can determine if the support was provided. Overall, there was improvement across the set of supports compared with the last review, though more work was needed to fully meet criteria with this indicator.

- For both individuals, three pre-move supports were not clearly measurable.
  - Of these, one was for providing transition assistance to various places Individual #197 or Individual #86 might want or need to go, but the evidence requested was for observation of the vehicle and insurance, which would not substantiate whether assistance was being provided. This appeared to be primarily a wording issue; the pre-move support should be for presence and availability of transportation and then the evidence would be correct.
  - Another support for both individuals called for provision of a home free of environmental and safety hazards, but it was not specified what types of hazards might be included. The Center indicated in interview it used a checklist for documenting this support, but did not make such a document available for review.
  - The final unmeasurable pre-move support for both individuals called for 24 hour awake staff to ensure safety, acclimating to a new environment, and assisting with daily living skills. This was an improvement over other supervision supports the Monitoring Team has seen recently, but still did not address what specific individualized safety concerns there might be for either person. Given Individual #197's history and target behavior of flight and Individual #86's history of sexual abuse in a group home setting, these were significant omissions.
- For Individual #197, many post move supports were measurable, but this was not the case across all of his supports. Examples of those that were not included:
  - Supports for inservice training provided some detail as to what should be included, but had no training methodology or competency requirements.
  - A support called for Individual #197 to receive a weekly allowance, but no amount or range was specified.
  - A support indicated Individual #197 should remain "as independent as possible" in toileting and dressing.
  - A support said staff should encourage Individual #197 to be actively involved in activities at the group home and day program. These "encourage to" supports are not measurable because they only assess staff action in a subjective manner and not whether the individual is actually actively involved. Without some specific criteria related to his needs, it was also not possible to quantify what was meant by actively involved.
- For Individual #86, many post move supports were measurable, but again this was not for all of her supports. Examples of

supports that were not measurable included:

- Three supports for inservice training provided some detail as to what should be included, but had no training methodology or competency requirements.
- A support called for her to receive a weekly allowance, but no amount or range was specified.
- A support indicated she would continue her low calorie diet. This was vague and should have specified 1200 calories.
- A seizure record was to be put in place to be monitored daily by nursing, but did not specify what staff should observe for or record.
- She was to be encouraged to make healthy food choices. This was vague and subject to interpretation.
- Some other supports were technically measurable, but were missing a measurable staff knowledge component.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. Neither of these CLDPs met the full criterion, as described below:

- Past history, and recent and current behavioral and psychiatric problems: Neither the ISP or assessments provided sufficient history regarding behavioral and psychiatric needs for Individual #197 and Individual #86.
  - Examples for Individual #197 included:
    - Individual #197's CLDP contained no supports for testing specific staff competencies related to his behavioral and psychiatric needs, in large part, because competency criteria were undefined.
    - Individual #197 had an autism diagnosis and several assessments indicated consistency in daily routine was important. The support said only that staff should encourage him to follow a daily schedule on a daily basis. This was vague and generalized, failing to define specific expectations. For example, there was no indication of a schedule to be followed or any testing of staff understanding.
    - The required level of supervision was not well-documented, even though Individual #197 had flight (i.e., elopement) listed as a target behavior. There was no staff knowledge support related to his need for supervision in various settings.
    - Individual #197 had been restrained five times since his admission and the frequency was increasing shortly before his transition, but there was no evidence that provider staff were trained as to how to deal with this in the community setting. The training materials provided were focused on how this was to be done at the Center, including, for example, contacting the switchboard operator for a restraint monitor to come to the scene. There was no support related to training of provider staff in appropriate and safe restraint techniques.
    - Psychotropic medication side effects were to be monitored, but there was no staff knowledge support regarding signs and symptoms to monitor and report.
    - The facility's transition dental assessment indicated Individual #197 should not have Ketamine, Zoloft, or Risperdal, but this was not noted in any support.
  - Examples for Individual #86 included:
    - There were no supports for specific staff competencies because competency criteria were undefined.
    - Individual #86's behavioral health assessment reported her supports did not, and were not likely to, reduce her target behaviors related to anxiety from past trauma, so it was unclear why there had been no counseling or other treatment for PTSD or any similar support developed.
    - Individual #86 was not to be restrained by male staff due to her history of possible emotional and sexual

abuse. No specific support was developed.

- There were some apparently conflicting statements about her reactions after visits with her mother and with her father. It was unclear if behaviors occurred after visits with one or both. Supports only stated to maintain contact with the family and mother through letters and visits. It did not require any sort of assessment to be completed following interactions with the family. A previous restriction on her father's visits had been lifted based on the mother's decision, but there appeared to be no rationale provided about whether the behaviors cited for the restriction had abated.
- Individual #86 had a history of depression, but the CLDP did not specify how this was manifested or treated, when it occurred, or any signs and symptoms to monitor and report.
- Side effects to be monitored included metabolic syndrome, extrapyramidal symptoms (EPS), hyperglycemia, weight gain, and hyperprolactinemia. There was no staff knowledge support regarding signs and symptoms to monitor and report.
- There were references to a history of unprovoked aggression and possible sexual abuse in a group home setting, but the CLDP provided insufficient detail to allow the IDT to consider any supports that might be needed to prevent recurrence.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: For both individuals, supports for various follow-up appointments and consultations appeared to be comprehensive, which was positive. Otherwise, there were a number of concerns identified by the Monitoring Team in the areas of safety, medical, healthcare, therapeutic, risk, and supervision needs, including the following:
  - The supervision level for Individual #197 was listed as 24 hour awake staff, in part to ensure his safety, but supports did not indicate whether he required, for example, line of sight supervision while outside at the home or day program or while out in the community, nor did it specify whether he needed to be checked on some regular basis while in the home. This was even more significant an omission in his case because of his history and target behavior of flight. Another support indicated he was to receive routine supervision, but this was not individualized.
  - Assessments noted new onset seizure activity, with results from an EEG pending. The CLDP did not provide any specific description of what type of seizure or what seizure activity looked like, but the support required a daily seizure log. It was unclear whether the pending results had been shared with the provider agency.
  - There were no specific supports for staff training and knowledge related to some health care concerns, other than a general support for inservices to be provided regarding the PNMP, diet, and adaptive aids. Examples of concerns included lack of specific staff knowledge and competency supports regarding signs and symptoms related to his diagnosis of constipation and his history of poor fluid intake and need for verbal reminders.
  - Individual #86's supervision level was listed as 24 hour awake staff to assist with acclimating to new environment, but the support indicated supervision was to be routine. There was no definition of any specific concerns related to acclimation, if any.
  - Individual #86 was to be encouraged to make healthy food choices, but there was no related support.
  - All of the following needs and/or recommendations were found in assessments, but there were no specific supports for the need, nor staff training or staff knowledge:
    - She had recurrent yeast infections requiring she be encouraged to dry thoroughly after showers and baths and

taking Florastor.

- There were no supports for signs and symptoms for direct support staff to be aware of and report as it related to PTSD due to reported rape in 2011.
- She was on birth control, but no support was addressed.
- Due to renal calculi, it was recommended that discontinuation of her calcium supplement be considered if her osteopenia improved. This was not addressed.
- She had many refusals for medical appointments, but no support specifically addressed how the community provider should approach this issue or provided any description of strategies that had worked in the past.

- What was important to the individual was captured in the list of pre-/post-move supports:
  - The CLDP for Individual #197 met criterion. The use of his iPad and communication strategies were of utmost importance to him and these were well integrated in his supports. Many other identified preferences were incorporated in his supports for leisure and recreation. The IDT defined other important outcomes as continuing outings and activities he enjoy, maintaining contact and visits with dad and grandmother and continuing to attend public school. Supports were present for weekly outings and enrollment in public school. There was a support for staff to encourage family contact and visits on a monthly basis. It included encouraging visits in the group home with staff to monitor (but it should have clarified why monitoring was needed or what required monitoring).
  - For Individual #86, what was important to her was minimally addressed. Examples included:
    - The CLDP stated she would like to join a sewing group and the ISP and PSI also noted she would like to learn to sew, but there was no related support.
    - Per her ISP/PSI, community excursions were important to her and she had an action plan to plan out her leisure activities weekly. This would have been a good support to continue in the community, but the identified support was to have opportunities to go on outings at least twice per month. It was unclear this would be substantially different from what she did while living at the Center, and one of advantages of community living should be more opportunity for community participation.
    - Individual #86 enjoyed church in the community and church singing. A related support was to have opportunity to attend church twice per month, or more if possible. Based on her preferences and what should be increased opportunities while living in the community, it was not clear why this would be limited to this minimal frequency. It represented a great opportunity for relationship-building, participation, and integration if the support had been more thoughtfully constructed.
    - Based on her interest in puppies, her leisure goal in the ISP was to visit PetSmart, with a secondary purpose of developing a potential vocational goal. There was no related support considered in the CLDP.

- Need/desire for employment, and/or other meaningful day activities:
  - Individual #197's supports addressed enrollment at public school and at a day program during vacations and holidays. There was no specific skill acquisition or learning identified to occur at the day program, only to participate in group activities. Supports did not address future employment preferences and needs, which he should be developing at the age of 18. Supports also did not address any other meaningful day activities in integrated community settings.
  - The assessment of Individual #86's needs and preferences related to employment was somewhat disjointed, with what

appeared to be several missed opportunities. Her personal goal in the ISP was to visit PetSmart, which was further conceptualized by the IDT as having potential to bloom into a community employment goal. She also had goal for working at an enclave job at Chili's two hours per week. The recent vocational assessment stated her vision was to work in a small area providing janitorial services where a supervisor was available to encourage and praise her for work completion. There were no specific employment-directed supports that reflected any of these goals or preferences; rather, it was recommended community she attend sheltered workshop up to six hours per day until community employment opportunities could be developed. The IDT did note that Individual #86 often changed her mind about her interests, including for employment preferences, but this would have called for the IDT to update this information and perhaps consider a support that related to vocational exploration. It is important for the IDT that knows her well to craft supports that take her specific habits, preferences and needs into account.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success: Neither of the CLDPs addressed positive reinforcement, incentives, and other motivating components well. For Individual #197, the availability of communication tools and various preferences for activities were included in supports. This was positive, but there were a number of specific positive reinforcement and motivating components in the behavioral health discharge assessment that were not well represented in the list of supports. Individual #86's psychiatric assessment noted her mother's participation in doctors' appointments made it more likely she would go. Such refusals of needed health care were a significant issue for her, but the IDT did not develop a support to take advantage of this motivating factor.

- Teaching, maintenance, participation, and acquisition of specific skills:
    - Individual #197 had one training goal, to brush his teeth with verbal prompts. Other supports for skill maintenance were limited to verbal prompting for various ADLs and a support to remain as independent as possible with toileting and dressing on a daily basis. There was one training goal for the day program, but this was only to participate in group activities with verbal prompts and was not specific to any learning needs. Individual #197 had been learning to make a sandwich before transitioning, which would have been very appropriate to continue to work on in a community home, where he ostensibly had greater opportunity to practice and use this skill. It was not included in his supports.
    - Individual #86's supports for learning and skill acquisition were limited to verbal prompting to brush teeth and to participate in group activities at the day program to increase her interactions with peers and social skills. Other ADLs were addressed only through verbal and physical prompting. The FSA Summary did not have current data and conflicted with other assessments regarding her relative independence, such as in telephone use. It was also documented in more than one place that she wanted to learn to sew, but this was not addressed.

- All recommendations from assessments are included, or if not, there is a rationale provided: There were recommendations that were either not addressed or did not have an adequate rationale provided for not being included. Examples included:
    - Individual #197 should not receive three medications per the dental assessment, but this information was not addressed in any support.
    - For Individual #86, it was recommended discontinuation of her calcium supplement be considered if her osteopenia resolved or improved, but this was not addressed.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: The facility continued to provide good post move monitoring, though as indicated in the detail below, improvements in actions and in documentation are required in order to meet criteria with these indicators. This is especially true for the important supports of community provider staff training and their expected resultant knowledge and competencies. At the time of this review, the Post Move Monitor position was vacant, the position was posted, and had not been filled,			Individuals:									
#	Indicator	Overall Score	197	86								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	0% 0/2	0/1	0/1								
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1								
6	The PMM's scoring is correct based on the evidence.	0% 0/2	0/1	0/1								
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	NA	N/A	N/A								

Comments:

3. Post-move monitoring had been completed for three post move monitoring periods for both Individual #197 and Individual #86. These were timely and included observations at all locations. The post move monitoring reports were done in the proper format. They generally included comments regarding the provision of every support, but some were not thorough in addressing the support. With improvement, it is likely that criteria can be met for this indicator in the future.

- For Individual #197, the Post Move Monitor (PMM) provided impressive detail for many supports and the overall summaries

for each visit were helpful for understanding the status of the transition. Comments for inservice supports were not as thorough as others, however, and provided little detail as to the presence of specific staff knowledge or competency. Instead, these typically indicated only that staff were knowledgeable in all areas and that there were no issues or concerns.

- For Individual #86, the overall summaries for each visit were also helpful for understanding the status of the transition. Many supports had detailed comments, but some did not have enough detail to substantiate findings. For example, a support called for a home free of environmental and safety hazards, but the comments only documented that utilities were on and that the home was neat and orderly. The comments for 24 hour awake staff referenced presence, but did not provide any information about staff knowledge of the needs cited for that level of support.

4. Reliable and valid data that report/summarize the status regarding the individual's receipt of supports were not consistently available. Examples included:

- For Individual #197, it was not always possible to ascertain whether reliable and valid data were present, due in part to a lack of specificity and measurability of some supports. This is described under indicator #1 above. For others, such as supports for inservice of staff, the data collected indicated only that staff were knowledgeable in these areas, without specific comments for each of the items. So, for example, flight was a behavior listed in the behavioral challenges inservice support, but the PMM's comments did not indicate that any specific knowledge was tested in this area. Shortly after, at the 45-day review, the PMM indicated this support was present, but it became apparent that day program staff were not aware of this concern and what was to be done to prevent it. Rather, they indicated they were not aware and were routinely allowing him to be outside by himself without supervision.
- It was similarly not possible to assess whether Individual #197 was remaining as independent as possible in toileting and dressing, or receiving verbal prompts for ADLs.
- At the 90-day post move monitoring visit, the PMM saw Individual #197 leaving the day program unaccompanied and had to re-direct him back inside, but the support related to staff knowledge of behavioral challenges indicated no issues or concern were noted.
- It was not always possible to determine if reliable and valid data were present for some of Individual #86's supports, again due in part to lack of specificity and measurability of some supports. For example
    - A support called for her to be encouraged to make healthy food choices, but the evidence provided only stated that observations, interviews, and checklist confirm the support was being met. It was not possible to assess the reliability and validity of the data with this lack of detail. Checklists used by provider staff for documentation did not contribute any additional detail that could have been used to substantiate the presence of the support.
    - A support called for Individual #86 to continue to utilize her PBSP on a daily basis and provider staff to track and document behaviors on a daily basis. The PMM correctly marked the support as not met at the time of the 45-day visit, due to lack of staff inservice and knowledge. This support was scored as present at the 7-day and 90-day PMM visits, but none of the three visits provided evidence that indicated what behaviors were being tracked and whether data were collected on a daily basis as required.

5. Based on information the PMM collected, these individuals were not consistently receiving all of the supports described or listed in the CLDP and sufficient justification was not provided.

- The PMM indicated Individual #197 was receiving many supports as required, but there remained instances in which they

were not, but should have been. Examples included:
    - Day program staff not were not inserviced on his iPad at the time of the 7-day PMM visit.
    - A neurology consult and Gardasil injection had not been received as required per the 90-day PMM Checklist.
- Due to the lack of measurability of some of Individual #197's other supports, it was not possible to ascertain from the data collected whether they were in place as required. For example:
    - It was not known what the specific expectations were for an environment free of environmental and safety hazards, and the evidence indicated only that the PMM did not observe any such hazards. It was reported that the community provider staff used a checklist to measure this support, but the Center did not provide a completed checklist for review.
    - A support called for 24 hour awake staff for the purposes of ensuring Individual #197's safety, acclimating to new environment, and assisting with daily living skills. Evidence indicated only that 24 hour staff were provided. Staff interviews were required as evidence, but this support did not indicate whether staff knowledge should include safety issues, such as flight.
- For Individual #86, the PMM also indicated many supports were being received as required, but there remained instances in which they were not, but should have been. In addition to those described under indicator #4 above, examples included:
    - Individual #86 had, like Individual #197, a support calling for 24 hour awake staff for the purposes of ensuring her safety, acclimating to new environment, and assisting with daily living skills, but evidence indicated only that 24 hour staff were provided. While this supervision support was an improvement over others the Monitoring Team has reviewed in terms of providing some expectation related to the need, it was exactly the same as Individual #197's and illustrated the potential problems with using standardized support language without being specific about individualized needs.
    - Several training supports for Individual #86 were not met due to day program staff not having been inserviced as required prior to the start of her attendance, and then again at the time of the 90-day PMM visit.

6. Based on the lack of measurability for supports defined in the CLDP, the Monitoring Team could not confirm the PMM consistently scored correctly if supports were provided as required. It was not always possible to assess based on the level of detail provided. In several instances for both individuals, the PMM relied on provider checklists to help substantiate presence, but those made available for review did not provide any further detail that would add to the measurability of the support. For example, for Individual #197, the checklist used by the provider included the support that he would remain as independent as possible with toileting and dressing on a daily basis. The provider staff were to make a check for each day. It did not specify how provider staff would determine that he was remaining as independent as possible.

7. It was positive that the IDTs met routinely to review the results of each PMM visit, but the Center still needed improvement in consistent implementation of corrective actions in a timely manner.
- Following the PDCT of 7/13/16, in which Individual #197 left the day program unobserved and was later returned by law enforcement personnel, the re-inservice of provider staff was not documented as being completed until 8/9/16 and 8/13/16. Considering the potential risk, follow-up should have been taken to ensure this was completed immediately.
- For Individual #86, there was a concern that the LAR was considering asking for discontinuation of her psychiatric medications, which was in conflict with the IDT-defined support and with provider preference. The PMM informed the IDT, which continued to be very much opposed to discontinuation. The PMM asked the provider to contact Lufkin SSLC if the

community psychiatrist recommended any changes. The IDT should have considered whether any other more preventative actions such, as speaking with the LAR about the IDT's rationale or consultation between psychiatrists, may have been in order.

8. Every problem had not been followed through to resolution.
   - For Individual #197:
     - It appeared there should there have been additional provider staff re-training on flight and level of supervision after he was observed by the PMM leaving the day program at the 90-day PMM visit. None was required.
     - The IDT met on 8/24/16 and indicated his Gardasil immunization would be obtained within one week, but no documentation was provided the Center had confirmed this was completed.
     - At the same meeting on 8/24/16, it was agreed his neurology appointment, which was overdue, was to be scheduled as soon as possible. On 10/19/16, the Center received notice it was scheduled for 10/24/16. This was not timely and documentation of resolution was not available as of the writing of this report.
     - The Monitoring Team also reviewed the inservice materials received from the provider as follow-up to his PDCT of leaving the day program. Two inservices noted flight as a behavior, but still described his level of supervision only as routine. This did not reflect the specific agreement that he would be supervised when out of doors at the day program.

9-10. Post move monitoring did not occur during the week of the onsite review. Therefore, these two indicators could not be scored.

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

Summary: One individual had no negative events occur. The other had serious negative events that included emergency room visits and law enforcement contact. A review of the incidents, the CLDP, and the transition assessments showed that some supports were missing from the CLDP that would have reduced the likelihood of these incidents having occurred. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	197	86							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	0/1	1/1							

Comments:

11. Individual #86 had not experienced any negative events as of the time of the monitoring visit. Individual #197 had experienced three PDCT events prior to the submission of the Monitoring Team's document request:
   - Emergency room (ER) visits occurred on two occasions. One was for frequent urination, which may have been related to medication changes the CLDP advised against. The IDT determined it could not have been anticipated, but the IDT should have

considered whether a doctor to doctor consultation between the Center and community psychiatrists may have prevented this, and whether, even now, such a consult post transition might make sense for Individual #197. While it was unknown whether this was preventable, the potential existed that a consultation may have been beneficial in this regard. The PDCT ISPA should also be used by the IDT for purposes of process improvement for future transitions. This is why it is essential for the IDT to think very critically about how it might do things differently in the future, based on the outcomes and experiences related to PDCT events.

- The second ER visit was a medication error that could not have been anticipated.
- The third PDCT event occurred when Individual #197 left the day habilitation program without the knowledge of staff and crossed a busy street to a day care establishment. His absence was not recognized until law enforcement was called and they notified the day program. The provider staff indicated they were not aware of his history of flight. These circumstances indicated the inservice training process may have needed improvement.

Individual #197 continued to experience additional negative events between the time of the document request and the monitoring site visit. Both of these began in the school setting.

- Per the interview with the APC and transition staff, he had experienced two such events at school on 10/7/16, including an ER visit and law enforcement contact. It was reported he was having difficulty adjusting to the new environment. A public school Admission, Review and Dismissal (ARD) committee meeting had been requested by the provider and was held on 10/12/13. Although Lufkin SSLC staff offered to participate, there was no documentation this had occurred. The APC did receive feedback from provider staff about next steps planned at the ARD, including a visit to the home by school staff. Lufkin SSLC also offered to meet with the provider and assist with any additional inservice that might be helpful, but these was no documentation this had occurred. No documentation was provided of a PDCT meeting by the IDT related to these events.
- A sixth negative event occurred on 10/17/16. Individual #197 was engaging in head-banging behavior at school and sustained a laceration requiring ER treatment. The last documentation available prior to this report, dated 10/21/16, was that Lufkin SSLC had not yet received the report of the most recent ER visit.

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

Summary: This outcome focuses upon a variety of transition activities. Lufkin SSLC made good progress, especially by including a lot of this information within the CLDP, though as detailed below, now improvements in quality are needed. Also, the completion/review of all relevant assessments as well as the quality of transition assessments are areas of focus for the APC and her staff. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs. The facility staff worked very well with the local authority, which increases the likelihood of a successful transition for individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	197	86							

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

Comments:

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

- Updated with 45 days of transition: The Center did not review or update the Integrated Risk Rating Form (IRRF) for either of the individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process. For Individual #197, updated pharmacy and vocational assessments were also not provided for review. For Individual #86, the Functional Skills Assessment

(FSA) was dated 10/16/15, although the title indicated it was a summary for 2016. The information contained was not updated to reflect the most recent ISP. An updated pharmacy assessment was also not provided for review.

- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments that were not available or updated to reflect current status had a negative impact on the scoring of this indicator for both individuals. Otherwise, the remainder of assessments met criterion in this regard.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that were not available or updated to reflect current status had a negative impact on the scoring of this indicator for both individuals.
    - For Individual #197, others that did not provide a comprehensive set of recommendations that would be adequate for planning or focus on the new settings included the medical and social work assessments. For example, the social work assessment noted a concern expressed by the grandmother about Individual #197's father taking him unsupervised due to concerns she had about the father's mental status. The assessment did not further examine this issue and the recommendation did not take this into account, stating only that family contact should be encouraged.
    - For Individual #86, the QIDP, social work, vocational, behavioral, medical, and nursing assessments did not meet criterion. Some recommendations were overly broad, such as the QIDP recommendations that Individual #86 could function in a less restrictive environment if supports and services were in place to meet her needs.
- Assessments specifically address/focus on the new community home and day/work settings, and identify supports that might need to be provided differently or modified in a community setting: Assessments did not consistently meet criterion for this indicator. For Individual #197, for example, there were no specific supervision recommendations regarding his flight risk. For Individual #86, several assessments noted a history of unprovoked aggression and possible sexual abuse in a group home setting, but assessments did not provide sufficient detail or recommendations to allow the IDT to consider any supports that might be needed to prevent recurrence.

13. The Monitoring Team considers three sub-indicators when evaluating transition documentation for this indicator.

- There was documentation to show IDT members actively participated in the transition planning process: Criterion was met for this sub-indicator. It was helpful that the Lufkin SSLC CLDPs explicitly discussed certain components of the participation of IDT members in the transition process, such as the training of provider staff. IDT members also participated in pre- and post-move ISPAs.
- The CLDP specified the SSLC staff responsible for transition activities, and the timeframes in which such actions are to be completed: Most supports identified only the provider Program Director or other provider staff as responsible. The Center should also designate SSLC staff with primary responsibility for ensuring actions are completed as needed.
- The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting: Criterion was met for this sub-indicator. Individual #197 attended pre-move ISPAs and the CLDP meeting. The CLDP also indicated there was review with the father, Individual #197's primary correspondent. There was considerable documentation of review with Individual #86 and her mother.

14. Documentation did not indicate Center staff provided training of community provider staff that met the needs of the individual, including identification of the staff to be trained and method of training required. Training did not define the training methodology or competency criteria and did not include any competency testing or demonstration. It was also stated the Post Move Monitor would

complete competency based training during post move monitoring, but it was unclear how competency would be determined at that time, or whether the Post Move Monitor had expertise in all potential areas needing such training. The Monitoring Team was also concerned that some training, for Individual #86, may have provided erroneous information. The training material provided for review included the restriction that the father could not take her off campus, but this had been discontinued. The training material provided also indicated she had no restraint contraindications, but other material indicated she was not to be restrained by male staff due to her history of sexual abuse.

15. For both Individual #197 and Individual #86, the CLDPs did not provide an adequate determination of the need for collaboration between facility staff and community clinicians. It was positive the CLDPs included a specific discussion as to whether any collaboration was needed, but should provide more detail as to the determination. The description of the discussion was limited to documentation the Placement Coordinator asked if any professional collaboration was needed or requested, and that none were requested by the IDT. Particularly in Individual #197's case, it would have been important to document a discussion and rationale as to collaboration needed between physicians and between speech-language pathologists.

16. These two CLDPs did indicate that the IDT considered this transition activity, and determined no further environmental assessment was needed for the individual, based on team members having seen the settings at the time of the pre-placement visit. It was helpful the IDT included this statement in the CLDP, but should provide more detail that specifies what environmental assessments should be completed based on individual needs and the specific results of these. It appeared from the available documentation that Individual #86 did not have needs that would require any clinical environmental assessment, but this was less clear for Individual #197. His environments should have been assessed for the level of stimulation as it related to his autism diagnosis and whether the settings presented any concerns related to his target behavior of flight.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the facility, facility direct support staff spending time with the individual in the community, and facility and provider direct support staff meeting to discuss the individual's needs. The CLDPs for Individual #197 and Individual #86 included statements about staff activities and collaboration, but did not address any of these examples. Some activities addressed would not appear to qualify as specific collaboration, such as that the community provider would ensure residential staff were present on the day of transition. Otherwise, the collaboration described was for inservice training. The IDT should consider whether other collaboration specific to the individuals' needs would be in order and document their rationale. For example, it may have been appropriate for the IDT to consider whether Individual #197 would benefit from having provider and Center direct support staff spend time with him together, given his need for consistency in his routine, and document the rationale for the decision.

18. Lufkin SSLC staff and the LIDDA engaged in activities to meet the needs of both individuals. This was an area of strength for the Center. For both, the receiving LIDDA completed the Continuity of Care Pre-Move Site Review and participated in the CLDP. The CLDP also documented the Placement Coordinator began communicating with both the Local and Receiving LIDDA upon provider choice and throughout transition. For Individual #197, the LIDDA service coordinator was unable to attend some ISPAs, but requested an additional meeting to discuss her concerns with the IDT and consider strategies. Frequent communication with the Post Move Monitor was documented. For Individual #86, the LIDDA participated in ISPA regarding available openings.

19. Neither of these CLDPs met criterion for pre-move supports being in place in the community settings on the day of the move. While many pre-move supports appeared to be in place, it was not possible to determine if the full intent of the supports for 24 hour awake staff was met. There were no specific criteria related to safety, acclimation to the new environment, and assistance with ADLs and the Pre-Move Site Reviews did not document any interview as to whether staff were knowledgeable in this regard. It was also not possible to discern whether the homes were free of environmental and safety hazards based only on a statement the Post Move Monitor didn't observe any. In interview with the transition staff, it was discussed that the Post-Move Monitor used a checklist to make this assessment, but none was provided for review as requested. This could have been a way to make this support more measurable as well as to document its presence or absence.

Meeting the requirements for Pre-Move Site Review was also a problem for another individual, Individual #6. In this case, the facility delayed his move until the provider corrected the environmental issues found during the pre-move review. During the onsite week, a meeting was held to review the status and schedule his transition because the issues were now corrected. The individual actively participated in this meeting, too.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: Both individuals transitioned in a timely manner. With sustained performance, this indicator may move to the category of less oversight after the next review. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	197	86							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1							

Comments:
20. Both individuals transitioned in a timely manner. Individual #197's referral date was 1/15/16 and he transitioned on 5/23/16. Individual #86 was referred on 11/9/15 and transitioned on 3/31/16.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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