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. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

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

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

Executive Summary

At the beginning of each Domain, the Monitors provide a brief synopsis of the findings. These summaries are intended to point the reader to additional information within the body of the report, and to highlight particular areas of strength, as well as areas on which Center staff should focus their attention to make improvements.

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

At the conclusion of the last onsite review and in the executive summary of the last monitoring report, the Monitors requested an action plan to address five areas of particular need at the Center: aspiration pneumonia risk, decubitus ulcers, protection from harm, engagement in activities, and quality assurance/quality improvement. In the nine months since the last review, the Center developed, implemented, and revised a Corrective Action Plan for each of these five areas. The Monitors were glad to see attention being paid to each of these areas and appreciated the various presentations and sharing of data and updates during the onsite week. In addition, the Monitoring Teams learned about various activities occurring at the Center by attending each of the four units' morning unit meetings, the monthly QAQI Council meeting, some of the daily morning medical/clinical meetings, and a number of ISP and ISPA meetings. The Monitoring Team also met with the unit directors and heard about some of their accomplishments, successes, and challenges. They were an experienced group of managers who were present and visible throughout the onsite week.

Despite these efforts, outcomes for a number of individuals continued to be poor, and substantially more work is needed to ensure that individuals are adequately protected from serious harm. Examples of continued problems, particularly with regard to aspiration pneumonia, and skin integrity are provided throughout this report. Efforts need to be interdisciplinary, and work is needed to improve quality assurance mechanisms, as well as staff's accountability in a number of areas. Below are some comments from the Monitoring Teams regarding the five CAP areas:

- Aspiration pneumonia: The Center made some progress in the review of individuals with a confirmed diagnosis of pneumonia. During the onsite review, the meeting for Individual #584 that Monitoring Team members attended highlighted the collaborative nature of this review. There was excellent facilitation and the process resulted in important discussions that were driven by clinical curiosity. That being said, based on the Monitoring Team's additional document review, it remained unclear whether or not the IDT fully investigated all potential underlying causes for the aspiration pneumonia, such as the December 2016 change in seizure medication and its resultant change in Individual #584's functional status. As discussed onsite with the Medical Director and members of the PNMT, caution is warranted in arriving at a single cause for a potentially multi-factorial clinical event such as pneumonia. It is important for the teams to investigate all potential causes and rule them in or out with the understanding that IHCPs might need to address more than one underlying cause. Once the etiology or etiologies are identified, the PNMT and/or IDT should focus the goals and actions on prevention and prediction rather than on reaction to another recurrence of the issue. Based on the Monitoring Team's post-onsite review of the resulting IHCP, more work is needed to ensure that IDTs capture in measurable terms important action steps that result from these "root cause analysis" meetings.

  Unfortunately, based on data the Center submitted in response to the Monitor's initial document request, in the six months prior to the review, 14 individuals experienced a total of 19 aspiration pneumonia events. One individual who

died had aspiration pneumonia listed as a cause of death. Of note, in its presentation to the Monitoring Team, Center staff provided substantially different data, which the Monitoring Team later discussed with staff. Moving forward, it will be important for the Center to continue to improve upon its progress thus far in the "root cause analysis" discussions, and the development and implementation of thorough and measurable IHCPs.

- Skin integrity: In order to address skin integrity issues, the Center will need to employ an interdisciplinary approach. The CAP focused largely on residential staff and nursing staff (e.g., development of acute care plans), but only minimally addressed Habilitation Therapy staff's role and, to an even lesser extent, medical staff's role. Although the CAP included some important steps, State Office and Center staff should review the CAP in light of findings throughout this report related to skin care issues for the specific individuals reviewed, and revise it as necessary. As illustrated through some of these individual examples, individuals continued to experience significant skin issues that did not receive prompt treatment consistent with current nursing and medical guidelines. In addition, the Monitors note the following overall concerns:
    - Based on information the Center submitted for the individuals the Monitoring Teams reviewed, IDTs were not assessing individuals' risks sufficiently, and IHCPs did not include interventions for daily skin assessments, as appropriate, or did not define the frequency for follow-up.
    - Based on the data provided from January 2013 through May 31, 2017, the majority of pressure ulcers were facility-acquired. During this period, the majority of pressure ulcers were initially discovered at Stage II, III, IV, or documented as unstageable. As recently as May 2017, the Center noted a number of acquired pressure ulcers that were discovered and noted at Stage II, III, and a IV. In order to address the overall skin integrity concerns, staff need to identify and address skin issues much earlier in the process.
    - The Center reported taking actions to further enhance early recognition of skin integrity problems through education and training of staff, and staff reporting their skin integrity observations to nurses. Nurses play a key role in assessing skin issues and early recognition of problems. During the Monitoring Team's onsite visit, during two observations, a direct support professional brought skin integrity issues to the nurse, but the nurse did not appropriately assess the individuals. This was quite concerning.

- Protection from harm and incident management: The CAP is primarily a repeat of the monitoring tool's indicators. Self-monitoring of completion of the activities required to meet criteria with these indicators should continue, but the CAP should include actions related to the most important issues around protection from harm, incident management, and conduct of investigations. As is illustrated throughout this report, a number of the individuals the Monitoring Teams reviewed had experienced harm, and were at continued risk of harm due to lapses in care and treatment. The Center should focus on ensuring that it has systems in place to identify areas in need of improvement, as well as proactive mechanisms for reducing the risk of harm to the extent possible.

- Engagement in activities: The CAP detailed many actions and activities that were to occur. Most were completed. These were directly related to increasing the number and variety of opportunities for engagement in activities. While onsite, the Monitoring Team observed many of these in action. The Monitoring Team also met with the Center's director of active treatment, the ADOP, and the state office discipline coordinator to learn more about these actions, too. Overall, these activities were a large improvement from what was observed during the last monitoring review and were heading the Center in the right direction towards increased, and regularly occurring, engagement opportunities for individuals. Details are provided in a number of sections of this report, though in particular in engagement outcome 7, indicators 18-21.

- Quality assurance/quality improvement: The CAP focuses upon root cause analysis and upon the structure of the QAQI Council meeting. Both are good and important aspects of quality assurance/improvement. In addition, the CAP should also focus on ensuring that the QA program at the Center has the right components and processes. State Office should provide assistance for that content.

  Overall, the existence of valid and reliable data and analysis of data were insufficient to provide the Center with meaningful information to determine progress or lack thereof in critical areas. For example, Center staff provided the Monitoring Teams with varying data on basic information, such as numbers of diagnoses of aspiration and other pneumonia events, individuals' falls, etc. Extracting data from IRIS continued to be a concern at Lufkin SSLC, as at other Centers. Valid and reliable data is one of the basic elements of a solid QA/QI system. The Center should focus on improvement of such basic aspects of its system.

Status of Compliance with the Settlement Agreement

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

This domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. At the last review, 11 of these indicators were moved to the category of requiring less oversight. During this review, three other indicators had sustained high performance scores and will be moved to the category of requiring less oversight. These were in the area of restraints.

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

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

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

Restraint

Lufkin SSLC continued to be very attentive to the usage of crisis intervention restraint. The behavioral health services director presented, graphed, analyzed, and examined the data in many different ways, which provided good information to the facility and informed IDTs and the behavioral health services department staff. These data analyses showed that a large percentage of the crisis intervention restraints were with one individual, a new admission, and that the trend line of the frequency for that individual was descending. The average duration of a crisis intervention physical restraint was the lowest in years for Lufkin SSLC (but still the highest in the state). Various restraint-related projects were in place: video review of restraint, pilot project using blocking pads, staff training on imminent danger, and special review for two individuals. Psychiatry input was occurring as required regarding the use of crisis intervention chemical restraint.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: conducting timely assessments; monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and following applicable nursing guidelines.

Abuse, Neglect, and Incident Management

Important protections were in place prior to all 12 incidents, including background checks, duty to report forms, and related treatment programs (e.g., PBSP, psychiatry, level of supervision). This was good to see. One investigation was conducted under streamlined investigation protocols and met the various DFPS and DADS criteria.

The quality of the facility-only investigations was very good. Information in the UIR was presented in a logical sequential order and in understandable language. They were easy to read and to follow the facility's path to their conclusions.

Some areas in need of attention are correct reporting within required timelines, proper posting of reporting information posters, and specification of alleged perpetrator reassignment in the UIR. Also, improvements were needed in the quality assurance/improvement program for incident management.

Other

Some, but not yet all, IDTs were reviewing the need for pretreatment sedation and considered whether treatment strategies should be developed.

It was positive that for the individuals reviewed, Center staff followed proper procedures in relation to the administration of oral pretreatment sedation for medical treatment.

During this review, improvement was noted with regard to the Drug Utilization Evaluations (DUEs) the Center completed, as well as follow-up activity.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.	
Summary: Lufkin SSLC continued to be very attentive to the usage of crisis intervention restraint. The behavioral health services director presented, graphed, analyzed, and examined the data in many different ways, which provided good information to the facility and informed IDTs and the behavioral health services department staff. Even so, overall, usage of restraint did not show a stable low trend of usage across the nine months (though a 10th data point, added for June 2017 showed a recent large decrease). The behavioral health services director's data analysis was able to show that a large percentage of the crisis intervention restraints were with one individual, a new admission, and that the trend line of the frequency for that individual was descending. The average duration of a crisis	Individuals:

intervention physical restraint was at the lowest average in years for Lufkin SSLC. It was 2.5 minutes lower than last time, on the average lower (but still the highest in the state). These indicators will remain in active monitoring.											
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	67% 8/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	44% 4/9	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (September 2016 through May 2017) were reviewed. Across this period, the census-adjusted rate of crisis intervention restraint was stable, even perhaps somewhat ascending. Moreover, when looking across the four nine-month periods, overall, there was an ascending trend.

The director of behavioral health services completed a number of types of data presentations and analyses each month as part of her QAQI report. In it, in addition to these 12 data sets, she presented lots of other restraint-related data and narrative analysis, such as the number of behavioral episodes against the number of crisis intervention restraints (because some behavioral episodes included more than one crisis intervention restraint), the different types of crisis intervention physical restraint (e.g., horizontal side-lying, arm hold), various content reviewed by the Monitoring Team in the indicators in this domain, and individual-specific restraint frequencies. For example, for the latter, she identified that one individual, who was a new admission (Individual #19), accounted for 25% to 50% of the crisis intervention restraints each month. The trend of the frequency of his crisis intervention restraints was descending over the past few months. This is not uncommon at many SSLCs, that is, often individuals are admitted due to serious behavioral disorders and incidents exhibited in the community. These behaviors sometimes continue occur upon admission, requiring crisis intervention restraint and, over time, the frequency decreases. Lastly, the director of behavioral health services presented the most recent month's data to the Monitoring Team (for June 2017). These data showed the lowest number of crisis intervention restraints since February 2015. This was also good to see; these data will be part of the data set that will be reviewed at the next onsite review.

Regarding the three categories of crisis intervention restraint: the use/trend of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint because the majority of crisis intervention restraints were crisis intervention physical restraints, the use/trend of crisis intervention chemical restraint was not descending due primarily to the high number March 2017, and the use/trend of crisis intervention mechanical restraint was low and stable. The average duration of a crisis intervention physical restraint was at just over eight minutes. Although the highest in the state (statewide average is just over four minutes), the duration at Lufkin SSLC had shown a steady decreasing trend over the past four nine-month periods, from a high of 26 minutes to the current number.

The number of injuries that occurred during restraint was low and all were non-serious. The number of individuals who received crisis intervention restraint each month showed a slightly increasing trend, at about 15 individuals per month, about the same as at the time of the last review. One individual had protective mechanical restraint for self-injurious behavior (Individual #410), and this was well

documented (and included in the behavioral health services director's monthly QAQI report). No individuals were reported to have had PMR-SIB changed to medical restraint or protective devices.

There was one occurrence of the use of non-chemical restraint for medical procedures over the nine months, about seven occurrences of pretreatment sedation for medical procedures each month (a stable trend), a slightly descending trend of individuals who had TIVA for dental across the nine months, and three occurrences of pretreatment sedation for dental over the nine months.

Thus, facility data showed low/zero usage and/or decreases in eight of these 12 facility-wide measures (duration of crisis intervention physical restraint, use of crisis intervention mechanical restraint, number of injuries during restraint, number of individuals with PMR-SIB, use of restraints for medical and dental procedures).

Overall, Lufkin SSLC attended to the use of restraint, focused upon ways to decrease its usage, and attempted to implement it correctly and safely when needed. To that end, the facility held a monthly safety committee during which the behavioral health services director presented and discussed her detailed QAQI report. In addition to the report and meeting, the facility reported implementation of these actions:

- Video recordings of implementation of crisis intervention restraint were reviewed by the behavioral health services staff. The number reviewed was a function of whether the restraint occurred within camera view and how many occurrences there were in the month.
- If crisis intervention restraint was implemented for two individuals who had various medical issues (Individual #401, Individual #145), a full review with the IDT, including direct support professionals, was conducted.
- Training for staff to fully understand the definition of imminent danger (i.e., when, and when not, to implement crisis intervention restraint) was conducted in one home (561B) and, subsequently, there were fewer crisis intervention restraints. This training was being considered for other/all homes at Lufkin SSLC.
- Lufkin SSLC was conducting a pilot project regarding use of blocking pads as a way to reduce the need for some crisis intervention restraints.

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. Six received crisis intervention physical restraints (Individual #279, Individual #237, Individual #401, Individual #415, Individual #19, Individual #170), and two received crisis intervention chemical restraints (Individual #237, Individual #401). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for one (Individual #237). The other three 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: Crisis intervention restraint continued to be well managed at Lufkin SSLC. Implementation under appropriate circumstances and after a graduated range of less restrictive measures have been exhausted were at 100% for this review and the past two reviews, too, with one exception in October 2016 for an	Individuals:

occurrence that the facility, at that time, had self-identified and corrected. Therefore, these two indicators, 5 and 10, will be moved to the category of requiring less oversight. The other three indicators (7, 9, 11) showed improvement; they will remain in active monitoring.												
#	Indicator	Overall Score	279	237	401	415	19	170				
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
4	The restraint was a method approved in facility policy.											
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 10/10	2/2	2/2	2/2	1/1	2/2	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
7	There was no injury to the individual as a result of implementation of the restraint.	90% 9/10	2/2	2/2	2/2	1/1	1/2	1/1				
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	50% 4/8	0/2	Not rated	1/2	1/1	2/2	0/1				
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 10/10	2/2	2/2	2/2	1/1	2/2	1/1				
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 10/10	2/2	2/2	2/2	1/1	2/2	1/1				

Comments:
The Monitoring Team chose to review 10 restraint incidents that occurred for six different individuals (Individual #279, Individual #237, Individual #401, Individual #415, Individual #19, Individual #170). Of these, eight 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.

7. For Individual #19 5/25/17, the applicable entry said not applicable.

9. Because criterion for indicator 2 was met for one individual, this indicator was not scored for her. The various sub-indicators were met for four of the remaining eight restraints for the other five individuals. Those that did not meet criteria were due to individualized engagement (Individual #279, Individual #401), implementation of day goals (Individual #279), implementation of communication plan (Individual #401), and need for psychiatric diagnostics and inclusion of potentially relevant variables, such as sleep, falls, work attendance, blood pressure, and weight (Individual #170).

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.												
Summary: Improved performance was found during this review, that is, at 100% compared with the last two reviews, which were both scored at 60%. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	279	237	401	415	19	170			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
Comments:												

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.												
Summary: Improved performance was found during this review, improved from a score of 64% at the last review. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	279	237	401	415	19	170			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 10/10	2/2	2/2	2/2	1/1	2/2	1/1			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Comments:												

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.												
Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: conducting timely assessments; monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and following applicable nursing guidelines. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall	279	237	401	415	19	170			

		Score									
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	20% 2/10	1/2	0/2	0/2	1/1	0/2	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	30% 3/10	1/2	0/2	1/2	1/1	0/2	0/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	33% 3/9	1/2	0/2	1/1	1/1	0/2	0/1			

Comments: The crisis intervention restraints reviewed included those for: Individual #279 on 1/26/17 at 3:41 p.m., and 3/24/17 at 4:42 p.m.; Individual #237 on 12/22/16 at 9:46 p.m., and 3/24/17 at 6:03 p.m. (chemical); Individual #401 on 3/5/17 at 1:05 a.m. (chemical), and 4/11/17 at 11:49 a.m.; Individual 415 on 3/27/17 at 3:53 p.m.; Individual #19 on 3/12/17 at 4:35 p.m., and 4/28/17 at 8:10 p.m.; and Individual #170 on 4/7/17 at 9:02 a.m.

a. For five of the 10 crisis intervention restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #279 on 3/24/17 at 4:42 p.m.; Individual #237 on 12/22/16 at 9:46 p.m., Individual #401 on 3/5/17 at 1:05 a.m. (chemical), and 4/11/17 at 11:49 a.m.; and Individual #19 on 3/12/17 at 4:35 p.m.

For five of the 10 restraints, nursing staff monitored and documented vital signs. The exceptions were for Individual #279 on 3/24/17 at 4:42 p.m.; Individual #237 on 12/22/16 at 9:46 p.m., Individual #401 on 3/5/17 at 1:05 a.m. (chemical), and 4/11/17 at 11:49 a.m.; and Individual #170 on 4/7/17 at 9:02 a.m. Problems varied, but included a lack of documentation of respirations, even if an individual refused other vital signs; lack of follow-up for abnormal vital signs; and no vital signs documented.

Nursing staff documented and monitored mental status of the individuals for three of the 10 restraints. Often, nurses documented "alert and oriented" without providing specific descriptions of the individuals' behaviors.

b. and c. Some examples of problems included:

- For Individual #279's restraint on 3/24/17, it was not clear in the Injury report if any of the noted skin integrity issues occurred during the implementation of the restraint.
- No nursing IPN was found for Individual #237's restraint on 12/22/16. Vital signs also were blank on the crisis intervention document, making it unclear whether or not further action was needed.
- For Individual #237's chemical restraint on 3/24/17, a nursing IPN indicated follow-up would occur for 24 hours, which was important due to the need to assess for possible hypotension and other adverse effects from the Ativan. The documentation the Center provided was confusing. Two copies of IView data were presented in different sections of the documents the Center provided to the Monitoring Team. The Face-to-Face Debriefing documentation evidently included an incomplete copy of the IView data for this episode. As a result, it appeared that nursing staff only documented vital signs in IView for five hours after the administration of the chemical restraint. In its comments on the draft report, the State stated: "Nurses monitored per protocol from time of administration of the Ativan @ 1808 3/24/17-3/25/17 @ 2043." Upon re-review of all of the documents for this restraint, the Monitoring Team identified the Center's error in including two different sets of IView documentation in response to two different document requests for the same restraint episode. The full set of IView documentation included in

the Medication Administration Record section showed nurses had conducted monitoring for 24 hours. However, the scores did not change, because nurses did not complete timely follow-up of a number of high and low vital signs.

- Again, for Individual #401's 4/11/17 restraint, the Center provided inconsistent and confusing information. As a result, in the draft report, the Monitoring Team concluded that nursing staff noted respirations were high, but then did not document follow-up. In its response to the draft report, the State pointed to the Integrated Progress Note (IPN) that noted high respirations, and then to the Face-to-Face Debriefing form on which the nurse noted follow-up. As the State's comments show, the nurse did not write an IPN to document the follow-up completed, which should be standard procedure. Because it appears follow-up did occur, the Monitor has modified the scores. However, it is essential that the Center and State address these documentation issues.
- For Individual #19's 3/12/17 restraint, the Nursing IPN at 5:47 p.m. documented that an injury report was filled out for the reopening of an old wound on his right elbow. Nursing staff did not follow the nursing guideline for describing the skin integrity issue, including length, size, depth, or if the individual was experiencing pain. In addition, nurses did not document what they did about the skin integrity issue (i.e., following any PRN orders for skin integrity or obtaining orders). In its comments on the draft report, the State questioned this finding stating that the nurse noted a description of the injury, completed a pain assessment, and provided treatment, noting no follow-up was needed. Upon re-review of all related documentation, the Monitoring Team was only able to find the following statement: "1cm re-opened abrasion on right elbow, with minimal bleeding R/T being restrained to the floor… No treatment needed, cleansed with water." As the Monitoring Team indicated in the draft report, this assessment was not consistent with standards of practice (i.e., it did not describe width, length, or depth). Although someone checked a box stating the individual did not have pain, the nurse's IPN did not describe a pain assessment (e.g., did the individual express pain when water was applied). Moreover, all skin integrity issues require follow-up, and none was documented. The Monitor did not change the related scores.
- For Individual #19's 4/28/17 restraint, nursing staff should have implemented the head injury protocol, but did not.
- For Individual #170, nursing staff did not re-assess the individual's high pulse rate or high blood pressure.

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

Summary: Performance maintained. Perhaps some sort of quality assurance review could catch any errors in information and result in higher performance. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	237	401	415	19	170			
15	Restraint was documented in compliance with Appendix A.	80% 8/10	2/2	1/2	2/2	1/1	1/2	1/1			

Comments:
15. One restraint had numerous errors in time entries (Individual #237 2/8/19) and one did not have the injury section completed (Individual #19 5/26/17).

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

Summary: Restraints were thoroughly reviewed for all of these restraints as well as

Individuals:

all restraints for the previous two reviews, too (with one exception in October 2016). Therefore, indicator 16 will be moved to the category of requiring less oversight. Implementation of recommendations also improved (indicator 17) and, with sustained high performance, might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.											
#	Indicator	Overall Score	279	237	401	415	19	170			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 10/10	2/2	2/2	2/2	1/1	2/2	1/1			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 3/3	1/1	N/A	N/A	1/1	1/1	N/A			
Comments:											

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)											
Summary: Criteria were met for both individuals to whom these indicators applied. With sustained high performance, indicator 47 might be moved to the category of requiring less oversight after the next review. This was the first time that indicator 49 received a high score. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	237	401							
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
49	Psychiatry follow-up occurred following chemical restraint.	100% 2/2	1/1	1/1							
Comments: 47-49. The psychiatrists were reviewing the chemical restraint occurrences in a timely manner, including clinical follow-up.											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.
Summary: Continued good progress was seen, especially regarding there being supports in place for every individual for whom an incident involved some behavior or aspect of their life that needed supports to reduce the likelihood of incidents Individuals:

occurring in the first place. Individuals who were designated for streamlined investigations required two sets of protocols to be followed. These protocols were being followed. This indicator will remain in active monitoring.

#	Indicator	Overall Score	517	237	401	415	19	170	40	3	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 12/12	1/1	3/3	1/1	2/2	1/1	1/1	1/1	2/2	

Comments:

The Monitoring Team reviewed 12 investigations that occurred for eight individuals. Of these 12 investigations, seven were DFPS investigations of abuse-neglect allegations (one confirmed, five unconfirmed, one unfounded and streamlined). The other five were for facility investigations of suicide threat, law enforcement contact, pica, and a serious injury. 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 #517, UIR 128, DFPS 45125275, unconfirmed allegation of verbal abuse, 1/26/17
- Individual #237, UIR 100, DFPS 45018972, unconfirmed allegation of neglect, 12/23/17
- Individual #237, UIR 171, suicide threat, 3/22/17
- Individual #237, UIR 189, law enforcement contact, 4/12/17
- Individual #401, UIR 141, DFPS 45147992, confirmed allegation of neglect, 2/10/17
- Individual #415, UIR 174, DFPS 45211164, unconfirmed allegation of neglect, 3/26/17
- Individual #415, UIR 153, suicide threat, 2/20/17
- Individual #19, UIR 120, pica incident, 1/12/17
- Individual #170, UIR 137, DFPS 45139711, unconfirmed allegation of verbal abuse, 2/6/17
- Individual #40, UIR 188, discovered serious puncture impalement, 4/11/17
- Individual #3 UIR 113, DFPS 45055165, unfounded allegation of abuse, streamlined investigation, 1/3/17
- Individual #3, UIR 190, DFPS 45236574, unconfirmed allegation of neglect, 4/12/17

1. For all 12 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.

Criteria were met for all 12 investigations. For all 12 investigations, related background checks and duty to report forms were done correctly. For seven of the 12, the investigation was regarding allegations of staff misconduct and for each of these, there were no relevant individual-related trends to be reviewed. For two of the other five, the behaviors exhibited by the individual had not occurred before. For the remaining three, the behaviors exhibited by the individual had been trended and were part of their treatment programs

(e.g., PBSP, psychiatry, level of supervision). This was good to see.

One investigation was conducted under streamlined investigation protocols and met the various criteria for this indicator, too.

Two of these individuals were assigned to the list of individuals who qualified for streamlined investigations based upon characteristics of their frequent calling in of alleged abuse that met DFPS' various criteria (Individual #237, Individual #3). Two sets of protocols were relevant. One was DFPS' regarding assignment and maintenance of one's name on their list. This was being followed, including monthly review and the removal of one of the two individuals from this list due to absence of frequent calling. The other was DADS' protocols for there to be a plan in place, for it to be reviewed, and for that information to be put forward. This was occurring; both individuals had plans that included addressing this behavior, and data were being collected.

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	517	237	401	415	19	170	40	3	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	75% 9/12	1/1	3/3	0/1	1/2	1/1	0/1	1/1	2/2	

Comments:

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

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

- Individual #401 17-171: The DFPS reported showed that the incident occurred on 2/3/17 and was reported to them on 2/10/17. The UIR showed an unknown reporter and that, at the time of the incident, it appeared that no one was sure the incident rose to the level of alleged abuse. Apparently, someone who was part of, or witnessed, the incident pondered over this for a week. Staff are to immediately report if they are suspicious of possible abuse/neglect.
- Individual #415 17-174: Per DFPS, this was reported to them at 7:31 pm. Per the UIR, this was reported to the facility director/designee at 8:41 pm, slightly past the one-hour requirement.
- Individual #170 17-137: Per DFPS, the incident occurred on 2/3/17 at 10:03 pm and was reported to them on 2/6/17 at 3:51 am, and then to the facility director/designee on 2/6/17 at 4:05 am. The UIR, however, stated that it was reported to the facility director/designee on 2/8/17 at 4:10 am. The UIR also stated that the reason for the delay in reporting was unknown due to having received the allegation via internet reporting. This may partially explain the late reporting to DFPS, but it doesn't

resolve the data conflict between when the UIR and the DFPS report that showed facility director/designee notification. The UIR should have identified the conflicting data and attempted to reconcile it to develop a scenario of what most likely happened in the reporting and alleged perpetrator reassignment sequence.

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: Staff interviewed were knowledgeable. Given some of the reporting delays described in indicator 2, above, this indicator will remain in active monitoring. Indicator 4 will also remain in active monitoring, primarily due to reporting poster availability.

Individuals:

#	Indicator	Overall Score	517	237	401	415	19	170	40	3	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 4/4	N/A	1/1	N/A	1/1	1/1	1/1	N/A	N/A	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	63% 5/8	0/1	1/1	1/1	0/1	0/1	1/1	1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
4. The reporting posters were not posted properly in the homes of three individuals.

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

Summary: With additional detail in the UIR and sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	517	237	401	415	19	170	40	3	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 12/12	1/1	3/3	1/1	2/2	1/1	1/1	1/1	1/2	

Comments:
6. For four investigations, the UIR did not specify alleged perpetrator reassignment. However, while onsite, additional documentation (the reassignment form) was presented and, as a result, those were scored as meeting criteria. This information should also be included in the UIR, which is the official report of the investigation.

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

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: Lufkin SSLC showed nice improvement on this outcome and its three indicators. All three indicators were scored at 100% for the 12 investigations (compared to 40% last time for indicators 8 and 9). They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	517	237	401	415	19	170	40	3	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 12/12	1/1	3/3	1/1	2/2	1/1	1/1	1/1	2/2	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 12/12	1/1	3/3	1/1	2/2	1/1	1/1	1/1	2/2	
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% 12/12	1/1	3/3	1/1	2/2	1/1	1/1	1/1	2/2	
Comments: 10. The UIR for Individual #237 17-171 was extremely well written. It was easy to read; the information flowed in a logical order. Protections in place prior to the incident were well described. The probable events section and analysis/concerns section were also well done. Overall, the quality of the facility-only investigations was very good. Information in the UIR was presented in a logical sequential order and in understandable language. They were easy to read and to follow the facility's path to their conclusions.											

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Indicator 13 improved since the last review, which was good to see. Details are provided in the comments below. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	517	237	401	415	19	170	40	3	

11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).										
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.	64% 7/11	0/1	2/3	0/1	2/2	1/1	0/1	N/A	2/2	

Comments:
12. Many of the DFPS investigations included extensions.

13. For Individual #40 17-188, the full investigation review was not yet completed at the time of this review, therefore, it was scored as N/A.

The absence of supervisor identification of the various late reporting, alleged perpetrator re-assignment, and absence of reconciliation of data in the UIR in four investigations resulted in these four investigations not meeting criteria for this indicator. 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:			Individuals:								
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.										

Comments:
15. For one individual, a non-serious injury investigation did not have the box checked to indicate whether an investigation was needed (Individual #415). For another individual, the discovered injury list did not indicate body location, thus, the Monitoring Team could not determine whether a non-serious injury investigation was needed (Individual #40 2/28/17).

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: Performance increased in this outcome for all three indicators, with all three improving to 100% compared to scores over the last two reviews that were, generally, in the 60% range. This was good to see. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	517	237	401	415	19	170	40	3	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 8/8	1/1	2/2	1/1	1/1	1/1	N/A	N/A	2/2	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 3/3	1/1	N/A	1/1	1/1	N/A	N/A	N/A	N/A	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 6/6	N/A	2/2	N/A	1/1	1/1	N/A	N/A	2/2	
Comments: For Individual #40 17-188, the full investigation review was not yet completed at the time of this review, therefore, these indicators were scored as N/A. 17. During this review period, staff in three cases were confirmed for physical abuse category 2. Employment was not maintained for any of these employees.											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. None met criteria. That being said, given (a) the improvements in a number of the outcomes and indicators of incident management (above) and (b) a focus on quality assurance/quality improvement (e.g., a CAP), the facility should be able to move forward in improvement in these important indicators, too. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	No									
20	Over the past two quarters, the facility's trend analyses contained the required content.	No									
21	When a negative pattern or trend was identified and an action plan	No									

	was needed, action plans were developed.											
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No										
23	Action plans were appropriately developed, implemented, and tracked to completion.	No										

Comments:
19-20. The data in the trend report was not complete, as required by these indicators. Very little was devoted to injuries. Most of the data were facility-wide. The incident management coordinator, while onsite, told the Monitoring Team that a new/revised way of presenting and reviewing/analyzing incident data was recently developed.

21-23. While onsite, the facility incident management department presented its CAP and also audit sheets for two UIRs to demonstrate efforts to meet the criteria for these three indicators. These summarized various probes relevant to indicators 21, 22, and 23 for the specific UIR (and presumably the individual who was the subject of the UIR). This was a very worthwhile endeavor and it was good to see Lufkin SSLC taking these steps. However, it did not address the intent of these three indicators, which is to use detailed data to try and identify important areas that require specific client protection-oriented action plans. For example, a review of detailed data could find: "a review of injuries from the last quarter shows that a disproportionate percentage occurred on 2nd shift in Unit A. Therefore, we are developing an action plan to address this. The action plan will include detailed action steps and the expected outcome(s) measured quantitatively." (Note, this is an example, it is not something that necessarily applied to Lufkin SSLC.)

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/4	0/1	N/A	N/A	N/A	N/A	0/2	N/A	N/A	0/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA need to be expanded and improved. The Dental Department did not have a policy that commented on medical clearance. The Medical Department did not submit any policies/procedures or guidelines in response to the Monitoring Team's request. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA, it is essential that such policies be developed and implemented.

For these four instances of the use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, and post-operative vital signs were documented. Except for Individual #170 (i.e., not all procedures were summarized), an operative note defined procedures and assessment completed.

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	170	120	235	46	584	59	62	188	221
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	100% 7/7	N/A	N/A	N/A	N/A	N/A	5/5	2/2	N/A	N/A
Comments: a. It was positive that for the individuals reviewed, Center staff followed proper procedures in relation to the administration of oral pre-treatment sedation for medical treatment.											

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: It was good to see that some, but not yet all, IDTs were reviewing the need for pretreatment sedation and considered whether treatment strategies should be developed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	120	401	415	19	170				
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	40% 2/5	0/1	1/1	0/1	0/1	1/1				
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	60% 3/5	1/1	1/1	0/1	0/1	1/1				
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A	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	N/A				

5	If implemented, progress was monitored.	N/A	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	N/A				

Comments:
1-6. This outcome and its indicators applied to Individual #120, Individual #401, Individual #415, Individual #19, and Individual #170 who all received pretreatment sedation in the last year.

1. There was evidence that Individual #401 and Individual #170's IDTs discussed behaviors observed during the procedure, other supports and interventions provided, additional supports or interventions that could be provided for future appointments, and the risk and benefit of the procedure without PTS versus with PTS.

Additionally, there was informed consent from the LAR/Facility Director. Individual #120 's ISPA/ISP, however, did not have evidence that her IDT discussed supports/interventions that could be provided for future appointments, or consent. Individual #415 and Individual #19 did not have evidence that their PTS was reviewed in their ISPs or ISPAs.

2. Individual #120, Individual #401, and Individual #170's 11/14/16 ISPAs indicated that their IDT determined, based on past history, that any action to reduce the use of PTS would be counter-therapeutic.

3-6. There were no treatments or strategies developed to minimize the need for PTS for any of the individuals.

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.			Individuals:								
#	Indicator	Overall Score	357	546							
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 2/2	1/1	1/1							
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/2	0/1	0/1							
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/2	0/1	0/1							

d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/2	0/1	0/1							
e.	Recommendations are followed through to closure.	0% 0/2	0/1	0/1							

Comments: a. Since the last review, two individuals died. The Monitoring Team reviewed both deaths, including:

- On 12/26/16, Individual #357 died at the age of 30 of fatal arrhythmia, hypertrophic cardiomyopathy, and bronchopneumonia; and
- On 1/10/17, Individual #546 died at the age of 59 of respiratory failure, aspiration, septic shock, and bilateral pneumonia.

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

- For Individual #357, the Quality Assurance Death Review (QADR) of Clinical Services identified 11 findings related to the care of this individual, including, for example, nursing staff not performing follow-up of assessments, failure to address abnormal vital signs, lack of appropriate dental care, failure to administer appropriate pneumonia vaccines, nursing staff not notifying the PCP regarding abnormal assessment findings, and PCPs not conducting post-hospital assessments within 24 hours. Not all of these findings resulted in recommendations in the QADR, and not all recommendations were carried forward to the Administrative and/or Clinical Death Review recommendations.

  There also was no explanation for how the cardiology assessment in 2015 showed no left ventricular hypertrophy (LVH), but the autopsy showed severe LVH a year later. The Administrative Death Review merely suggested that PCPs might want to use a different cardiologist.
- For Individual #546, the QADR identified 37 findings related to the care of the individual as well as documentation issues. Such issues included, for example, inaccuracies in the active problem list, discrepancies in immunization records, failure to address a possible blood loss in a timely manner, failure to obtain timely consults, failure to address Dilantin levels that were high, failure of nursing assessments to identify health issues, and problems related to the implementation of nursing acute care plans. Again, not all of these issues were addressed through recommendations.

e. In addition to missing recommendations, all recommendations that were made were not tracked to resolution (i.e., not just those in the Administrative Death Review should be tracked). In addition, not all the recommendations were written in a way that ensured that Center practice had improved. For example, a recommendation that addressed the need for nurses to send enteral feeding records in hard copy for filing resulted in the Nurse Operations Officer sending a memo to staff. This did not ensure that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not nursing staff were sending the records monthly as required.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: The Center did not appear to have a system to ensure that potential adverse drug reactions were reported immediately, further investigated, and probability scales completed. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	ADRs are reported immediately.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	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.	0% 0/1					0/1				

Comments: a. through d. Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed. However, based on the Monitoring Team's review, on 12/1/16, the PCP increased Individual #584's carbamazepine dose. In the weeks following, the individual experienced a functional decline in status. In a note on 12/28/16, a PCP summarized the decline stating that Individual #584 was "noted by staff to have AMS [altered mental status] and declined in ability to self-feed and pivot during transfer; Decline began in the beginning of the month of December. Vital signs were stable but the individual became more lethargic. Patient was screened and treated for UTI (E. coli) with Ciprofloxin. She was treated for a UTI. However, she continued to decline in ADLs. Medications were reviewed and it was noted that early in the month when patient had breakthrough seizures carbamazepine was increased from 300mg BID [twice a day] to an additional 400mg BID. Patient's previous labs also showed an elevated VPA [Valproic Acid] level." The PCP also indicated that the RN Case Manager attended the neurology clinic appointment on 12/22/16, "specifically to notify Neurology of the noted decline in patient since the start of additional medication of carbamazepine." However, this note was the first documentation by a PCP that addressed the increase in carbamazepine dose and the individual's overall decline in functional status.

In its response to the draft report, the State provided a highlighted document that showed that in December 2016, Individual #584 was prescribed a total daily dose of 1200 mg of carbamazepine (i.e., 100 mg QID and 200 mg QID). The cause of the discrepancy between what the PCP who summarized her decline thought she had received (i.e., 600 mg) and what the additional information from the Pharmacist showed (i.e., 1200) remains unclear to the Monitoring Team. Moreover, in its comments, the State indicated that the increase in December was from 1200 to 1400 mg, but based on the documentation the State highlighted, this is incorrect. In fact, the individual's dose was increased from 1200 mg per day to 1900 mg per day (i.e., 100 mg 1 tablet at noon, 200 mg 1 tablet at noon, and 400 mg 2 tablets BID = 100 + 200 + 800 + 800 = 1900).

The next neurology consult was dated 2/23/17, and stated that the individual was on 1400 mg a day (which appears to have been incorrect), and apparently since this dose was increased she became more lethargic and less functional. The recommendation was to decrease the CBZ to 1100 mg per day and monitor. It should be noted that this consult was requested due to "possible adverse reaction to seizure medications, decreased ADLs since Tegretol increase." Center staff did not report this ADR.

An ADR form should be completed for any suspected ADR. They should then be further investigated and probability scales completed. Based on the probability score, a suspected ADR should then be classified as doubtful, possible, probable, or definite.

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: During this review, improvement was noted with regard to the DUEs the Center completed, as well as follow-up activity. These indicators will remain in active monitoring.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 2/2

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

- A DUE to review the utilization of carbamazepine for the treatment of seizures and psychiatric disorders, dated 1/25/17; and
- A DUE to review the utilization of oral iron supplementation for the treatment of anemia and iron deficiency, dated 4/26/17. The DUE provided a recommendation to: "obtain a current complete work-up **prior** to initiating iron supplementation: CBC [complete blood count], iron panel, B12, folate, EGD [esophagogastroduodenoscopy], renal function." (Emphasis added.) While many aspects of this recommendation are appropriate, this is not the generally acceptable approach to the work-up for anemia. The approach to an individual with anemia continues to be that a CBC with platelets, white blood count (WBC) differential and reticulocyte count is requested along with a review of the peripheral smear. Further work-up is guided by the results of these initial tests. It is of utmost importance that individuals with documented iron deficiency and no obvious etiology, such as menstrual loss, have a thorough evaluation to determine the cause of iron deficiency. Algorithms providing the appropriate approach to the evaluation of anemia are readily available.

  In its comments on the draft report, the State indicated: "A provider would not start iron supplementation, order iron panels, EGD, etc. without an indication. The intent of this recommendation is to guide the prescriber after anemia has already been identified. The purpose of the DUE is to focus on medications and the prescribing thereof. There is no intent to teach the prescribers on 'algorithms providing the approach to the evaluation of anemia.'" As indicated in the draft report, the DUE included a recommendation about what providers should do prior to treatment. As the Monitoring Team pointed out, the algorithm offered was not correct.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the last review, 15 of these indicators were moved the category of requiring less oversight. For this review, four other indicators were moved to this category, in ISPs, psychology/behavioral health, and skill acquisition plans. Two indicators in nursing, however, were returned to active monitoring.

Behavioral health services remained a strong component of the clinical program at Lufkin SSLC. There were many staff who were certified as behavior analysts. Two new full-time psychiatry providers were now at Lufkin SSLC. There was a plan for them to be onsite one week per month with the other three weeks conducted electronically via video beginning in September 2017.

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

Assessments

The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting for about one-third of the individuals. IDTs did not arrange for and obtain needed, relevant assessments prior to the IDT meeting for all individuals, with one exception. Some key team members were not present at annual ISP meetings.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. As a result, 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.

At the time of the last review, because Medical Department staff had consistently completed annual medical assessments in a timely manner, the related indicator was placed in the category requiring less oversight. However, during this review, problems with timeliness were noted with three of the nine annual medical assessments reviewed. If this issue is not corrected, then this indicator will return to active monitoring.

Center staff should continue to improve the quality of the medical assessments, with particular focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, updated active problem lists, and plans of care for each active medical problem, when appropriate.

The quality of annual dental exams as well as summaries required continued attention.

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.

Comprehensive psychiatry evaluations were completed for all individuals. The IRIS format needs to meet Appendix B requirements. Most evaluations were missing some elements, most commonly, the bio-psycho-social formulation. For annual evaluations/updates, some elements were missing, most commonly, the derivation of target symptoms.

In behavioral health, goals and objectives were based upon assessments. Lufkin SSLC continued to collect data and assess its reliability. This was good to see. Individuals had current and complete annual behavioral health assessments. Functional assessments were current and complete for all but one individual.

Individuals had current FSAs, PSIs, and vocational assessments. Some did not include recommendations for SAPs. Some were not done in time for IDT review prior to the ISP.

Some improvement was seen with regard to the timeliness of referrals to the PNMT. The Center should focus on continuing to improve its progress in this area, as well as improving referral of all individuals that meet criteria for PNMT review and timely completion of the PNMT initial review, completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT comprehensive assessments.

The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied, and still requires improvement. Overall, many problems were noted with the quality of the OT/PT comprehensive assessments and updates reviewed.

A number of individuals reviewed had not had needed communication assessments. The one communication update reviewed for a teen-ager with identified communication strengths and needs was of poor quality.

Individualized Support Plans

ISPs were revised annually. The Monitoring Team observed some good meeting facilitation skills exhibited by the ISP facilitators. During an ISP observed during the monitoring visit, the psychiatrist attended and led the discussion regarding the individual's behavioral health.

Progress was seen in the development of individualized, meaningful personal goals. All six ISPs included three or more goals that met criteria, and one ISP had goals that met criteria in five of the six areas, for a total of 22 goals that met criteria. Further, 17 of these goals were written in measurable terms. None had goals that meet criteria in the health/wellness/IHCP area and, for all goals, only a handful were implemented sufficiently, correctly, and with adequately collected data to determine progress.

When considering the full set of ISP action plans, the various criteria included in the set of indicators in outcome 3 were not met. About half of the goals had action plans that were likely to lead to the accomplishment of the goal. About half had integrated preferences and opportunities for choice within the action plans. The plans did not address supporting/teaching informed decision-making. One ISP fully integrated strategies to minimize risks in ISP action plans. This was good to see and demonstrated the facility's ability to meet this requirement. Meaningful and substantial community integration was absent from most of the ISPs, though there were some interesting exceptions (Individual #237, Individual #506).

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.

There was also improvement in IDTs addressing of most integrated setting practices indicators. Higher scores were seen for almost all of the indicators of outcome 4. Areas for focus are the thoroughness of the living options discussion (and its documentation in the ISP), and plans to address obstacles and to educate individuals and their LARs.

Monthly QIDP reviews were occurring, but will need to include data for the month, summarization of progress, and revisions to action plans/supports, as needed, particularly when goals are not consistently implemented.

Individuals did not have psychiatry-related personal goals regarding reduction in problem symptoms and regarding increases in positive indicators of psychiatric functioning. The Monitoring Team had the opportunity to spend a number of hours with the new psychiatrists at Lufkin SSLC during the onsite week discussing this.

Most PBSPs contained all of the required components.

Overall, individuals' ISPs did not reflect their functional status from an OT/PT perspective, including strengths and needs, and did not reflect IDT discussion about changes needed to PNMPs. In addition, action plans in ISPs and/or ISPAs did not include recommended interventions.

Although many of the individuals reviewed likely should have had communication strategies included in their ISPs, the lack of current and/or quality communication assessments made it impossible to determine which clinically relevant supports should have been included in their ISPs. This is an area that requires significant effort to correct.

ISPs

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

Summary: Continued progress was seen. Although the development of individualized, meaningful personal goals in all six different ISP areas was not yet at criteria, but much progress was evident. All six ISPs, for instance, included three or more goals that met criteria, and one ISP had goals that met criteria in five of the six areas, for a total of 22 goals that met criteria. This was very good progress since the last review. Further, 17 of these goals were written in measurable terms, also demonstrating good progress. Unfortunately, none had goals that meet criteria in the health/wellness/IHCP area, and only a handful were implemented sufficiently, correctly, and with adequately collected data to determine progress. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	120	170	19	237	59	188			
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	4/6	3/6	5/6	4/6	3/6	3/6			
2	The personal goals are measurable.	0% 0/6	3/6	2/6	4/6	4/6	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	2/6	0/6	0/6	0/6	1/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #120, Individual #170, Individual #19, Individual #237, Individual #59, Individual #188). 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.

None of the six individuals had individualized goals in all six areas, however, there was improvement in the development of individualized goals based on preferences in some of the six areas. The Monitoring Team observed teams in annual ISP meetings and in ISP preparation meetings engaged in good discussions about goals. This was also evident in the meeting the Monitoring Team had with the QIDP coordinator and the QIDP supervisors.

For these six individuals, the IDT had defined some personal goals that met criterion for being individualized based on the individual's preferences and strengths. Overall, 22 of 36 personal goals met criterion for this indicator. This was an improvement from the past review when 17 of 36 goals met criterion. IDTs particularly struggled with writing individualized day/work/vocational and health care goals. Goals that met criterion were:

- Individual #120's goals for leisure/recreation, relationships, greater independence, and living options.
- Individual #170's goals for relationships, greater independence, and living options.
- Individual #19's goals for leisure/recreation, relationships, greater independence, work/day programming, and living options.
- Individual #237's goal for leisure/recreation, day programming, living options, and greater independence.
- Individual #59's goals for leisure/recreation, relationships, and living options.
- Individual #188's goals for recreation/leisure, greater independence, and living options.

Although IDTs had created the above goals (ones that were more individualized and based on known preferences than in the past), few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The facility needs to focus on barriers that are preventing individuals from achieving their goals and develop plans to address those barriers.

Examples of goals that did not meet criterion because they were not aspirational, individualized, and/or based on preferences included:

- Individual #170's vocational goal to increase his work attendance was based on compliance rather than skill building or preferences for work.
- Individual #237's relationship goal to form a friendship at school was not individualized to build on relationship skills that were identified by assessments.
- Individual #59's greater independence goal to communicate to her staff her need to use the restroom was a skill that she already had, according to staff. She was observed using the sign for toilet successfully with her staff. Her day goal to attend and remain in class was compliance based rather than building new skills based on her preferences.

2. Of the 22 personal goals that met criterion for indicator 1, 17 also met criterion for measurability. This was another sign of progress for the QIDPs and IDTs.

When personal goals for the ISPs did not meet the criterion described above in indicator 1, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process.

3. Three of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. As noted throughout this report, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of data and documentation provided by the facility. It appeared that few action plans were regularly implemented. There were data to support implementation of Individual #170's relationship and greater independence goals, and Individual #188's goal for greater independence.

The facility reported that QIDPs and other team members would be participating in additional training offered by the state office on ISP development. The training was to be focused on assessments, SAP development, and overall implementation. Hopefully, this will assist the IDTs in developing more functional goals that will support individuals to learn new skills based on their preferences.

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. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators refer to the full set of action plans. That is, the qualities that are being monitored by these indicators may be evident in different action plans within the set of goals and action plans for the individual. Of these 11 indicators, five showed improvement (including indicator 8) and one showed a decrease. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 120	170	19	237	59	188			
8	ISP action plans support the individual's personal goals.	0% 0/6	2/6	2/6	3/6	3/6	0/6	1/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	50% 3/6	0/1	1/1	0/1	1/1	1/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	67% 4/6	1/1	1/1	1/1	0/1	0/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the	17%	0/1	0/1	0/1	1/1	0/1	0/1			

	areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	1/6									
14	ISP action plans integrated encouragement of community participation and integration.	17% 1/6	0/1	0/1	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	0/1	0/1	1/1	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.	17% 1/6	0/1	1/1	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	1/6	1/6	0/6	2/6	0/6	1/6			

Comments:

8. Some personal goals did not meet criterion in the ISPs, as described above in indicator 1, therefore, those 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.

Overall, IDTs were struggling with developing action plans that supported accomplishment of goals. Action plans (and skill acquisition plans) often were not specific enough to ensure consistent implementation and measurement of progress. The QIDP Coordinator indicated that IDTs were receiving further training on the action plan development process.

For the 22 personal goals that met criterion under indicator 1, 11 had action plans that were likely to lead to the accomplishment of the goal. IDTs were struggling with developing action steps that would lead to measurable progress towards goals. Goals that met criterion included:

- Action plans for Individual #120's recreation and greater independence goal.
- Action plans for Individual #170's relationship and greater independence goal.
- Action plans for Individual #19's recreation, greater independence, and day goal.
- Action plans for Individual #237's recreation, day, and greater independence goal.
- Action plans for Individual #188's greater independence goal.

9. Three of six ISPs integrated preferences and opportunities for choice in the individuals' ISP action plans. Individual #120, Individual #19, and Individual #188's ISP did not meet criteria for this indicator. The facility was in the process of developing new options for day programming, however, at this time, ISPs include very few options for day programming based on preference assessments and individual choice.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making.

Under the leadership of the human rights officer and one of the program auditors, the self-advocacy committee was re-initiated since the time of the last review. This had developed into a small group that met each month. The Monitoring Team observed a meeting and talked with the human rights officer and program auditor afterwards to share some observations and suggestions. There may be some benefit in collaborating with another SSLC whose self-advocacy committee is at about the same point in development. Self-advocacy committee activities can be incorporated into ISPs for individuals, especially around group decision making and problem solving skills.

11. Four ISPs met criterion and two ISPs (Individual #237, Individual #59) did not meet criterion for this indicator. Individual #237 had an action plan to count her change when shopping, however, assessments indicated that she had this skill. Her ISP recommended an action plan to learn to cook healthy foods, however, this action plan was not developed. Many of Individual #237 and Individual #59's goals were stated in terms of "will participate," "will go/attend," and "will be provided the opportunity," without specifying what they would independently do to achieve the goal. Individual #59's ISP had a greater independence action plan to press a Big Mac button in her room to notify her staff that she needs to go to the restroom. It was observed that the button was located outside of the restroom in her home instead of in her room and that it was not functioning. Staff reported that Individual #59 effectively used the sign for toilet to notify staff that she needed to use the restroom.

12. One ISP (Individual #237) fully integrated strategies to minimize risks in ISP action plans. This was good to see. For the others, specific support strategies should be included in staff instruction for implementing action plans, when relevant, to minimize risks in all settings. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. Some examples where strategies were not integrated in the ISP included:

- Individual #120's IDT did not integrate mobility strategies into action plans for work and community outings.
- Individual #19's SAPs noted that staff should follow support strategies in his PBSP. Strategies, however, were not individualized for implementation of specific action plans. Behavior had been identified as a barrier to achieving his goals.
- Strategies to address Individual #170 and Individual #59's health risk were not integrated into action plans for community and day outings.
- Individual #188's healthcare strategies to address his high risk for choking, skin integrity, and behavior were not integrated into action plans to support his other goals. His high cardiac risk was not addressed in his IHCP.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In particular, medical supports were rarely integrated into support plans developed by other disciplines. The exception was that Individual #237's IDT did integrate health and behavioral supports into action plans. For example, she had action plans to exercise and monitor her blood pressure. In addition to the examples provided in indicators 11 and 12 above, other examples where discipline assessments and recommendations were not fully integrated included:

- For Individual #120, the IDT has not fully integrated medical, habilitation therapy, and behavioral recommendations regarding her reduced mobility.
- Individual #170's health and mobility strategies have not been fully integrated into all action plans in his ISP.

- Individual #59's communication strategies were not well integrated into her ISP. There was no indication that the IDT had adequately assessed her preferred use of sign language and/or trained support staff to respond to her sign language.
- For Individual #188, it was not evident that communication and mobility strategies were integrated into action plans.

14. Meaningful and substantial community integration was absent from most of the ISPs. The exception was Individual #237. She had action plans for community school and dance. Although not part of the Monitoring Team's review group, one individual's (Individual #506) IDT had successfully developed a community activity based upon the individual's strong preference for art and painting. That is, he enrolled and attended a community college art program that met once a week for a number of weeks. The individual enjoyed it and the team's plan was to find another class for him to take.

15. One of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #237 had a goal to return to general education classes. Overall, vocational/day assessments were not adequate for determining preferences and goals were focused on compliance rather than interests and skill building. For example:

- Individual #120 had a goal to obtain a job in the community, however, the IDT did not identify job preferences supports, or skills that she would need to obtain work in the community.
- Individual #170 had a work goal to increase his work attendance. His goal did not address his preferences, skills, support needs, or consideration for work in a more integrated setting.
- Individual #19 and Individual #59's IDT did not address school attendance in a more integrated setting.
- Individual #188's ISP did not identify his preferences for day programming. It was noted that further assessment was needed to identify his preferences. There was no indication that an assessment had been completed.

16. None of the ISPs supported substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Based on observations, individuals were rarely engaged in functional training during the day that might lead to gaining new skills and greater independence. The facility had developed a CAP to address engagement. Progress had been made in developing a broader range of options for day programming at the facility. This was good to see, however, new opportunities had not yet been integrated into individuals' ISPs. A greater focus should be placed on goals and action plans that support community integration and job skills.

- Individual #19 a had a wide range of action plans to participate in various activities based on his preferences, however, implementation for action plans were on hold due to restrictions implemented as a result of behavioral concerns. The IDT should develop activities and opportunities that he can participate in until restrictions are lifted.
- Individual #237's ISP also included action plans for participation in a variety of activities based on her preferences. Many of her action plans were not being implemented, in part, due to the absence of specific staff instructions to guide the staff in implementing her plans and encouraging skill building.

Improving engagement by offering new activities was a focus of the Lufkin SSLC over the past few months, including having it as one of the facility's five CAPs in response to the last monitoring report. Some examples are presented in this report in domain 4, skill acquisition and engagement section, outcome 7, indicators 18-21.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Most notably, barriers to consistent implementation of action plans were not addressed. The exception was for Individual #170, for whom the IDT identified barriers with strategies via BHS in the PBSP and via PNMT recommendations.

18. Five action plans were found to describe detail about data collection and review, however, overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated and, in many cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented. Action plans that met criterion were:

- Individual #120 and Individual #188's action plans to support their greater independence goals.
- Individual #170's action plans to support his living options goal.
- Individual #237's action plans to support her recreation and day goals.

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

Summary: Improvement was seen in this outcome and its indicators. Indicator 19 was at 100% and with sustained high performance, might be moved to the category of requiring less oversight after the next review. Of the other 10 indicators, higher scores were obtained for nine when compared with the last review. Areas for focus are the thoroughness of the living options discussion (and its documentation in the ISP), and plans to address obstacles and to educate individuals and their LARs. All of these indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 120	170	19	237	59	188			
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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	67% 4/6	1/1	0/1	1/1	0/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	0/1	1/1	1/1	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	100% 5/5	N/A	1/1	1/1	1/1	1/1	1/1			

	community).										
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	0/1	1/1	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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	20% 1/5	1/1	0/1	N/A	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0/1 0%	0/1	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Six ISPs included a description of the individual's preference and how that was determined.

20. The Monitoring Team observed the annual ISP meeting for Individual #74. The individual was very clear about his preferences.

21. Four of the six ISPs fully included the opinions and recommendation of the IDT's staff members. Those that did not meet criteria included:

- Several of Individual #170's assessments were submitted late for the annual ISP meeting, therefore, discipline recommendations were not available for review by the team. His PCP did not participate in the meeting. Input by the PCP would have been beneficial to the team given Individual #170's complex medical needs.
- Individual #237's ISP documented that each team member indicated that she could be served in the community. In summary, behavior was listed as a barrier to placement. It was not clear how this was determined, since it was not noted to be a barrier by individual team members.

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

23. Two of the individuals (Individual #170, Individual #19) had a thorough examination of living options based upon their preferences, needs, and strengths. For the remaining four, the ISPs did not reflect a robust discussion of available settings that might meet individuals' needs.

- For Individual #120, Individual #188, and Individual #59, it was not evident that the IDT discussed specific living options that might be able to provide the supports needed in the community (e.g., for Individual #59, a residential program with intensive behavioral supports).
- Individual #237's IDT agreed that supports and services might be available in the community, but failed to identify appropriate options based on the supports that she would need.

24. Five of five 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 #120 was referred to the community.

25 and 27. The Monitoring Team observed the annual ISP meetings for Individual #74. His long-time friend participated via telephone and also contributed to the discussion.

26. One of the six individuals (Individual #170) had individualized, measurable action plans to address obstacles to referral or transition, if referred. For the most part, action plans were not measurable, as noted above. Individuals had broad-based general action plans to participate in group home tours and attend provider fairs.

28. One of the ISPs (Individual #170) included specific action plans to educate individuals on living options when relevant.

- Individual #19 had recently lived in the community and was already familiar with living options.
- Individual #170, Individual #188, and Individual #59's action plans were not individualized or measurable.
- Individual #237's IDT identified LAR's wishes as the barrier to community placement. Her ISP did not included individualized action plans to educate her LAR on living options that might meet her support needs

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

Summary: ISPs were revised annually for all individuals for this review and the two previous reviews, too. Therefore, indicator 30 will be moved to the category of requiring less oversight. The other four indicators had about the same performance as in the past. Those four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 120	170	19	237	59	188			
30	The ISP was revised at least annually.	100% 5/5	1/1	1/1	N/A	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.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	17% 1/6	0/1	1/1	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	1/1	1/1	0/1	0/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			

Comments:
30-31. ISPs were revised annually. Individual #19 was admitted to the facility on 12/14/16. His ISP was developed on 2/8/17. This

did not meet the requirement to develop ISPs within 30 days of admission.

32. Documentation was not submitted that showed that all action plans were implemented on a timely basis for five of six ISPs. The exception was for Individual #170. Examples in which timeliness criteria were not documented included:

- For Individual #120, QIDP monthly reviews indicated that her recreation, relationship, and living option goals were not implemented within 30 days.
- Individual #19's recreation and living option goals were not implemented within 30 days.
- Individual #237's recreation and living option action plans had not been implemented.
- Individual #59's recreation and relationship goals were not implemented within 30 days.
- Individual #188's recreation and relationship goals have not been fully implemented.

33. Four of six individuals participated in their ISP meetings. Individual #237 and Individual #59 did not attend their annual ISP meetings.

34. One of the individuals had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process (Individual #19). Three of six LARs did not attend the annual IDT meeting. Other examples of key team members not present at annual ISP meetings included:

- For Individual #170, his PCP did not attend the meeting to address unresolved medical issues.
- For Individual #59, her SLP did not attend to help the IDT develop and integrate communication supports.
- For Individual #188, his PCP was not in attendance to address his healthcare risks, his PT did not attend to provide input into his mobility supports, and his nutritionist did not attend to provide input into supports addressing his weight issues.

Additionally, it was not evident that QIDP and other team members actively reviewed, monitored, and revised supports in a timely manner.

During observations of annual ISP meetings during the onsite review, the Monitoring Team observed some good meeting facilitation skills exhibited by the ISP facilitators. These included calling on various attendees to ask them questions and engender their participation, returning the group to talk specifically about the individual's goal(s) if the discussion wandered to far off to other topics, and involving the individual as much as possible. The PCP attended and participated at various times, including during the risk (IRRF) discussion. IHCP goals were presented (but not action plans). There remained a need for psychiatry goals.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Both indicators scored lower than last two reviews. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	120	170	19	237	59	188			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior	33% 2/6	0/1	0/1	1/1	0/1	1/1	0/1			

	to the annual meeting.										
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting for two of six individuals (Individual #19, Individual #59).

- Individual #120's IDT did not consider recommendations for further assessments by specialist to assess her loss of mobility.
- Individual #170's team did not adequately consider assessments related to his weight gain, including his intake and activity levels.
- Individual #188's IDT raised questions regarding his vision and supports needed for mobility related to his vision. Further vision assessments were not recommended.

36. One of the IDTs arranged for and obtained needed, relevant assessments prior to the IDT meeting (Individual #237). Without relevant assessments available to IDTs prior to the annual ISP meeting, it was unlikely that all needed supports and services were included in the ISP. QIDP assessment data indicated:

- Individual #120's OT/PT assessment was submitted late.
- Individual #170's FSA, Vocational, OT/PT, and nutritional assessments were submitted late.
- Individual #19's behavioral, dental, vocational, nutritional, and communication assessments were submitted late.
- Individual #59's PSI and communication assessments were submitted late.
- Individual #188's team did not document a recommended vision or orientation and mobility assessment.

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

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

Individuals:

#	Indicator	Overall Score	120	170	19	237	59	188			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs met when a serious incident occurred or a trend of incidents was identified (e.g., multiple falls, emesis, multiple restraint incidents). This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure recommendations were implemented. Furthermore, reliable and valid data were often not available to guide decision-making. As noted throughout this report, little progress was made towards achieving personal goals. IDTs rarely revised goals when progress

was not evident. Other examples where the IDT failed to take adequate action included:

- Individual #120's IDT met numerous times to discuss her lack of progress on her mobility goals. The team made frequent recommendations for further specialized medical assessments. It was not evident that this assessment had been completed.
- Individual #19's team met in May 2017 to review numerous emesis events. There were not recommendations for further assessments or supports. ISPAs to review restraint incidents did not include information required during the review of restraints.
- Individual #188's IDT met, as required, following a hospitalization and numerous falls in May 2017. The IDT did not make any recommendations regarding further assessment or revision in supports.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals. There was no evidence that IDT members were monitoring supports and services or took action when plans were not implemented.

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

Going forward, the QIDPs will need to be sure that they are gathering data for the month, summarizing progress, and revising the ISP, as needed, particularly when goals are not consistently implemented.

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
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.	22% 4/18	0/2	1/2	0/2	0/2	1/2	1/2	0/2	1/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed IRRFs addressing 18 specific risk areas [i.e., Individual #170 – weight, and falls; Individual #120 – circulatory, and urinary tract infections (UTIs); Individual #235 – constipation/bowel obstruction, and infections; Individual #46 – skin integrity, and hypothermia; Individual #584 – aspiration, and seizures; Individual #59 – choking, and dental; Individual #62 – gastrointestinal (GI) problems, and skin integrity; Individual #188 – cardiac disease, and falls; and Individual #221 – fractures, and skin integrity].

a. For the individuals reviewed, IDTs did not effectively use supporting clinical data, use the risk guidelines when determining a risk level, and as appropriate, provide clinical justification for exceptions to the guidelines. Many problems were noted. Overriding issues were a lack of complete data and a lack of analysis of existing data, including comparison from year to year.

b. It was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #120 – circulatory, Individual #59 – dental, and Individual #188 – cardiac disease.

Psychiatry

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

Summary: This outcome requires individualized diagnosis-specific personal goals be created for each individual and that these goals reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. The Monitoring Team had the opportunity to spend a number of hours with the new psychiatrists at Lufkin SSLC during the onsite week. This was one of the discussion topics. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
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	0/1	0/1	N/A
5	The psychiatric goals/objectives are measurable.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
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	0/1	0/1	N/A
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	0/1	0/1	N/A

Comments:
4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors or to the absence of side effects related to psychotropic medications. 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.

In other words, much like the other SSLCs, there were no individualized psychiatric goals for individuals. That is, those that focused upon the individual's psychiatric disorder and monitored progress via what have come to be called psychiatric indicators.

- To reiterate, there need to be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status.
- The goals need to be measurable, have a criterion for success, be presented to the IDT, appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents as well as be part of the QIDP's monthly review.

Psychiatric progress notes for quarterly clinical encounters routinely documented review of available data. Unfortunately, the data provided for psychiatry were reportedly reliable in only two cases, Individual #19 and Individual #517. In these two cases, as with the other individuals reviewed, the data being collected were not regarding psychiatric symptoms, but rather regarding specific behavioral challenges. These data were not useable for making decisions regarding the efficacy of the individual's psychotropic medication regimens.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: Performance was about the same for these four indicators, all of which will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
12	The individual has a CPE.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
14	CPE content is comprehensive.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
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.	0% 0/3	N/A	N/A	N/A	0/1	N/A	0/1	0/1	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.	63% 5/8	1/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1	N/A

Comments:
13. CPEs were completed for all individuals. All of the CPE examples were noted to include a large volume of information. The CPE regarding Individual #19 was completed in IRIS. While it was not technically in Appendix B format, it was apparent that the facility psychiatry staff had made an effort to include as much information as possible.

14. The Monitoring Team looks for 14 components in the CPE. One of the evaluations, regarding Individual #3, addressed all of the required elements. The other eight evaluations were missing anywhere from one to five elements. The most common deficiency was the bio-psycho-social formulation.

15. For the three individuals admitted since 1/1/14, all had a CPE completed within the first 30 days of admission. Individual #415's record did not include an IPN from nursing documenting the admission assessment. Individual #19's record did not include an IPN from nursing or primary care documenting the admission assessment. Individual #237's record did not include an IPN from primary care documenting the admission assessment.

16. There were three individuals whose documentation revealed inconsistent diagnoses, Individual #517, Individual #237, and Individual #415.

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

Summary: Indicators 18 and 20 showed decreased performance and indicator 21 remained at 0% performance. With the recent additions of two new full time psychiatric providers, it is likely that the psychiatry department's participation in the annual ISP will improve. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	120	517	237	401	415	19	170	3
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/6	0/1	0/1	0/1	0/1	0/1	N/A	N/A	0/1	N/A
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	50% 4/8	0/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1	N/A
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	0/1	0/1	N/A

Comments:
18. The Monitoring Team scores 16 aspects of the annual evaluation document. None of the evaluations met full criteria. The most common deficiencies in the annual evaluations were regarding the derivation of target symptoms. As data were being collected

regarding behavioral challenges, it was not possible to attribute these to a specific diagnosis. There was documentation linking behavioral challenges to a specific diagnosis in the record of Individual #120 and Individual #170.

20. The psychiatric clinician attended the ISP meeting in four of the cases. During an ISP meeting observed during the monitoring visit, the psychiatrist attended and led the discussion regarding the individual's behavioral health. This was good to see.

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

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

Summary: None of the individuals had a PSP. This indicator will remain in active monitoring for possible scoring at the next review.

#	Indicator	Overall Score	Individuals: 279	120	517	237	401	415	19	170	3
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:
22. None of the individuals in the review group had a PSP. Four individuals at Lufkin SSLC had a PSP. These were reviewed for content. Of the four, one did not include relevant psychiatric indicators (Individual #147), one seemed to indicate that a PBSP was needed instead of a PSP (Individual #185), one had good instructions for staff but did not indicate purpose of the PSP and also there were inconsistencies in the diagnosis listed (Individual #477), and one did not indicate the purpose of the PSP (Individual #568).

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

Summary: Including the required content in consent and ensuring each individual has consent documentation are aspects of psychiatry department activity that will need some attention from the new psychiatric providers. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	120	517	237	401	415	19	170	3
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	N/A
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	N/A

30	A risk versus benefit discussion is in the consent documentation.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
32	HRC review was obtained prior to implementation and annually.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	N/A

Comments:
28. Individual #401's record did not include consent forms for Depakote. As psychiatry had assumed the management of this medication, a consent form should have been completed.

29. The facility consent forms contained adequate medication side effect information.

30-31. The risk versus benefit discussion was not included in the consent forms. For non-pharmacological alternatives, the consent forms did not include individualized alternatives.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Goals and objectives were based upon assessments. This was the case for this review and the last two reviews, too. Therefore, indicator 4 will be moved to the category of requiring less oversight. Lufkin SSLC continued to collect data and assess its reliability. This was good to see and good results were found four individuals. Additional attention to ensuring that all reliability assessments are done and that, if scores are below criteria, that additional activities (e.g., training, re-checks) are done. Indicator 5 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.										

4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	44% 4/9	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1

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

5. All individuals had evidence of interobserver agreement (IOA) and data collection timeliness (DCT) assessments in the last six months. Individual #401, Individual #415, and Individual #19, however, had DCT levels below 80%. Additionally, Individual #237's DCT and IOA levels were below 80%, and Individual #170's IOA levels were below 80%, indicating that their PBSP data were not reliable. Ensuring the reliability of PBSP data should be a priority of the behavioral health department. It was good to see that Lufkin SSLC was checking these levels; actions should be taken to improve these levels.

One individual, a new admission, presented a variety of psychiatric, behavioral, and self-injurious behaviors (Individual #415). The behavioral health services department and IDT were attending to his unique needs by regularly modifying his program and environment, implementing various restrictions (e.g., access to items, safe bedding and furniture), and working to keep him safe.

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

Summary: Behavioral health updates were current and complete, which has been the case for some time at Lufkin SSLC. Therefore, indicator 10 will be moved to the category of requiring less oversight. Problems with components of functional assessments for one individual were found, though with sustained high performance, indicators 11 and 12 might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	120	517	237	401	415	19	170	3
10	The individual has a current, and complete annual behavioral health update.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A
11	The functional assessment is current (within the past 12 months).	86% 6/7	1/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	N/A
12	The functional assessment is complete.	86% 6/7	1/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	N/A

Comments:
Criteria for indicators 1-9 were met for Individual #120 and Individual #3. This was good to see. Therefore, the remainder of the indicators in psychology/behavioral health were not rated for them.

10. All seven individuals had current and complete annual behavioral health assessments.

11. Individual #279, Individual #237, Individual #401, Individual #415, Individual #19, and Individual #170's functional assessments were current. Individual #517's functional assessment was completed in the last year, however, was scored as 0 because the indirect assessment was completed in 2014. Indirect assessments should be conducted annually, or a rationale for why it was not practical or functional, to be done each year. In any case, indirect functional assessments should never be more than two years old.

12. Individual #279, Individual #237, Individual #401, Individual #415, Individual #19, and Individual #170's functional assessments were complete. Individual #517's functional assessment was rated as incomplete because the direct assessment did not include any target behaviors and, therefore, was not useful in identifying potential antecedent or consequent events that may be affecting his target behaviors.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.

Summary: PBSPs were complete, with one exception, for an individual who had more complex medical and physical support needs. This indicator 15 will remain in active monitoring, however, with sustained high performance might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 279	120	517	237	401	415	19	170	3
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
14	The PBSP was current (within the past 12 months).										
15	The PBSP was complete, meeting all requirements for content and quality.	86% 6/7	1/1	1/1	0/1	1/1	1/1	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. Six of the seven PBSPs contained all of those components. Individual #517's functional assessment indicated that escape from demands/environmental events maintained his target behaviors, however, his PBSP indicated that his target behaviors were maintained by positive reinforcement, negative reinforcement, tangible reinforcement, and automatic reinforcement. Therefore, his PBSP was judged as not based on his functional assessment and his PBSP was scored as 0.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.

Summary: For the one individual, criteria for both indicators were met. This was good to see. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	120	517	237	401	415	19	170	3
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 1/1	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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Comments: 24-25. Individual #237 was referred and received counseling services, and both her treatment plan and progress notes were complete. Individual #415 was also referred for counseling, however, had not begun counseling at the time of the onsite review.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Although Indicator b was moved to the category requiring less oversight, in reviewing individuals' annual medical assessments for other purposes, the Monitoring Team noted that three of nine individuals' annual medical assessments were not timely. If such issues are not corrected, then Indicator b might move back to active monitoring at the time of the next review. Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. Indicator c will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight. However, due to problems noted with timeliness of some annual medical assessments, Indicator b is at risk of moving back to active monitoring.									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	Comments: b. The following individuals' AMAs were not completed within 365 days of the prior AMA: Individual #170, Individual #584, and Individual #221. c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.										

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. Problems varied across the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included pre-natal histories, social/smoking histories, and past medical histories. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, updated active problem lists, and plans of care for each active medical problem, when appropriate.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #170 – other: hypothyroidism, and other: hypertension; Individual #120 – fractures (i.e., cervical spine fracture), and seizures; Individual #235 – respiratory compromise, and seizures; Individual #46 – constipation/bowel obstruction, and other: hypothyroidism; Individual #584 – respiratory compromise, and polypharmacy/side effects; Individual #59 – cardiac disease, and gastrointestinal (GI) problems; Individual #62 – diabetes, and cardiac disease; Individual #188 – respiratory compromise, and cardiac disease; and Individual #221 – osteoporosis, and weight].

As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

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.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
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	0/2	2/2	1/2	1/2	0/2	1/2	0/2	0/2	1/2

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

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #170 – other: hypothyroidism, and other: hypertension; Individual #120 – fractures (i.e., cervical spine fracture), and seizures; Individual #235 – respiratory compromise, and seizures; Individual #46 – constipation/bowel obstruction, and other: hypothyroidism; Individual #584 – respiratory compromise, and polypharmacy/side effects; Individual #59 – cardiac disease, and GI problems; Individual #62 – diabetes, and cardiac disease; Individual #188 – respiratory compromise, and cardiac disease; and Individual #221 – osteoporosis, and weight].

The IHCPs that sufficiently described the medical action steps necessary to address the individuals' chronic or at-risk conditions were those for: Individual #120 – fractures, and seizures; Individual #235 – respiratory compromise; Individual #46 – constipation/bowel obstruction; Individual #59 – GI problems; and Individual #221 – weight.

b. As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: The Center should focus on improving the quality of dental exams and summaries. Indicators b and c will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	Individual receives timely dental examination and summary:	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.										
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.										
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.										
b.	Individual receives a comprehensive dental examination.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: b. It was good to see that all of the dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral cancer screening;
- Sedation use;
- An oral hygiene rating completed prior to treatment;
- A description of periodontal condition;
- An odontogram;
- Caries risk;
- Periodontal risk;
- Specific treatment provided;
- The recall frequency; and
- A treatment plan.

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

- Information regarding last x-ray(s) and type of x-ray, including the date;
- Periodontal charting; and
- A summary of the number of teeth present/missing.

c. On a positive note, all of the dental summaries included the following:

- Recommendations related to the need for desensitization or another plan;
- A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret;
- Effectiveness of pre-treatment sedation;
- Recommendations for the risk level for the IRRF;
- A description of the treatment provided; and
- Treatment plan, including the recall frequency.

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

- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- Provision of written oral hygiene instructions (i.e., the phrase "Make minor improvements" does not meet this requirement); and
- Dental care recommendations (i.e., simply quoting the PNMP does not meet this requirement).

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.	
Summary: Due to previous high performance with regard to the completion of annual nursing reviews and physical assessments, Indicators a.i and a.ii moved to the category requiring less oversight. However, based on the annual nursing	Individuals:

assessments the Monitoring Team used for other elements of its review, problems were noted with regard to the completion of complete physical assessments, including weight graphs, fall assessments, and assessments of reproductive systems. As a result, Indicators a.i and a.ii will move back to active monitoring. 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	170	120	235	46	584	59	62	188	221
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.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight. However, due to regression in the completion of complete physical assessments, these indicators will move back to active monitoring.									
	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.										
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/15	0/2	0/1	0/2	0/2	0/2	0/1	0/2	0/1	0/2

Comments: a. Based on the Monitoring Team's use of annual nursing assessments and physicals for other elements of its review, problems were noted for all nine individuals with regard to completion of complete physical assessments, including weight graphs, fall assessments, and assessments of reproductive systems. In addition, abnormal findings (e.g., vital signs, pain) often did not result in further analysis, narrative, or follow-up. As a result, Indicators a.i and a.ii will move back to active monitoring. Similarly, quarterly physicals were missing these critical components.

This largely appeared to be due to issues with IRIS. The nurses on the Monitoring Team have discussed this issue with the State Office Nursing Discipline Lead. If this issue is corrected by the time of the next review, these indicators might move back to the category requiring less oversight.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #170 – weight, and falls; Individual #120 – circulatory, and UTIs; Individual #235 – constipation/bowel obstruction, and infections; Individual #46 – skin integrity, and hypothermia; Individual #584 – aspiration, and seizures; Individual #59 – choking, and dental; Individual #62 – GI problems, and skin integrity; Individual #188 – cardiac disease, and falls; and Individual #221 – fractures, and skin integrity).

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 #170, on 5/8/17, a nursing IPN reported a fall and stated: "unwitnessed jumping from shower chair." The nursing plan component of the IPN stated: "no further intervention at this time will notify PCP if bruising to torso or limited mobility occurs. [Individual] was trying to run lost his balance and fell face first." However, nursing staff did not document further assessment, for example, to determine whether or not bruising or limited mobility occurred.
- On 4/17/17, the PCP wrote an order for Individual #235 for stool collection for suspected C-Diff. infection. Nursing staff should have put contact precautions in place, while awaiting confirmation of the test, which was positive. On this date, the record indicated Individual #235 received an enema for constipation. The Nursing IPNs contained no information that precautions were discussed with the Infection Preventionist. No acute care plan was found.
- Between 5/4/17 and 5/5/17, nursing staff documented assessments of Individual #46's skin. However, they did not follow applicable nursing guidelines/protocols. For example, they did not utilize the Braden Scale, and/or compare results from previous findings. It also was perplexing that a nurse documented that on 5/4/17, a PCP contacted the nurse and asked the nurse to assess redness behind the individual's knee. As discussed in the medical section on acute issues, the PCP did not document assessment of any of the individual's multiple wounds.
- On 4/19/17, Individual #46 had a below-normal temperature of 96.8 degrees Fahrenheit. The next available nursing IPN that documented a temperature was dated 4/20/17, and the individual's temperature was 98.1. Nursing staff did not follow standards of care for following up on abnormal vital signs. More specifically, nursing staff did not follow guidelines for hypothermia, skin assessment, or cardiovascular issues. The IPNs provided no information to show that the temporal temperature was confirmed with a rectal temperature.
- On 5/16/17, nursing staff reported that at 7:35 a.m., Individual #584 vomited medication (1/2 cup pudding with medications), was shaking and shivering, and said she was cold. Nursing staff initiated oxygen, because she had an order for it, if her oxygen saturation fell below 92%. Nursing staff reported a call to the PCP, but the PCP did not answer, so Individual #584 would be seen in the medical clinic at an unspecified time. On 5/16/17 at 11:40 a.m., a nursing IPN reported: "B/P [blood pressure] 88/40, and she seems very lethargic O2 stats dropped to 82%. Physician notified, and transferred to ER." Nursing staff reported that they implemented the Respiratory Distress Protocol. The guidelines for notifying the physician if an individual's oxygen saturations are less than 95% were not followed. Nurses also did not describe the individual's

positioning in the IPNs. In addition, the IView documentation, dated 5/16/17 at 7:41a.m., recorded a high blood pressure, but the next vital sign was not documented until 5/16/17 at 11:52 a.m., when Individual #584's blood pressure was 88/50, and oxygen saturations were 89%. At that time, nursing staff called a physician who ordered a 911 transfer. Individual #584 was admitted to the hospital. Diagnoses upon admission included, but were not limited to hypoxia, acute respiratory failure, and sepsis due to aspiration pneumonia.

- On 2/23/17 at 5:30 a.m., an injury report noted: "[Individual #62] has 2 open areas on her sacral area." On 2/23/17, at 6:57 a.m., a nursing IPN documented an initial assessment that followed nursing standards of care for skin integrity assessment. A Braden scale was completed with a score of 15. However, follow-up Nursing Assessment did not consistently include the length and width of the wound, and if there was any depth to the wound. On 2/26/17 at 8:44 a.m., a nursing IPN noted a blister on her right buttock, and the nurse made a referral to the PCP. A corresponding medical IPN, dated 2/23/17 at 1:57 p.m., indicated the wound should be treated with Medihoney and a bandage. The nursing assessments documented in the IPNs were not specific enough to discern if the 2/26/17 wound was a new skin integrity issue. On 2/27/17 at 2:24 p.m., the PCP staged the right buttock ulcer as a "spot blister," and Stage I Pressure ulcer. However, on 2/27/17 at 4:48 p.m., a PT IPN documented it as a Stage II pressure ulcer. The IPNs included significantly conflicting information regarding Individual #62's skin integrity. The Center should ensure that when assessing skin integrity (i.e., not limited to pressure ulcers), staff follow Center guidelines and discrepancies are clearly reconciled.
- For falls that Individual #188 sustained on 3/19/17, 3/21/17, and 3/22/17, nursing staff did not follow nursing guidelines for fall assessment and/or head injury assessment, as applicable.
- On 2/2/17, Individual #221 sustained a fracture of the left foot fifth metatarsal. Although on 2/2/17 at 1:30 p.m., a nurse reported an assessment of "swelling and bruising to left foot," and a direct support professional reported a "change in gait," no IView documentation was found to show a nursing evaluation of the potential injury. In the IPN, the plan noted an attempt to notify the Medical Department LVN and APRN, and that another RN would attempt to notify the LVN and APRN during the 2 p.m. to 10 p.m. shift. The next nursing IPN entry was dated 2/2/17 at 8:45 p.m. On 2/3/17, Individual #221 was assessed during sick call, and x-rays and pain medication were ordered. It is concerning that nursing staff did not assess the individual immediately upon receiving the report of a potential injury from the direct support professional. Moreover, no acute care plan was found.
- For Individual #221, the nursing IPN, dated 3/9/17 at 12:36 p.m., noted possible additional skin breakdown on her left arm, and stated: "there is an additional area of her fifth finger, noted as unstageable." On 3/10/17 at 10:30 a.m., a PT IPN noted: "seen at the request of the RN Case Manager, [Individual #221 has two more pressure wounds from the cast, discovered after the orthopedist further cut down her splint. It was described [as on the] radial aspect of her left wrist. The wound is purple with a thin layer of white eschar." The PT recommended duoderm be applied to the radial wrist wound. A medical order, dated 3/9/17 at 2:55 p.m., was found for referral to Habilitation Therapy for treatment. At the time nursing staff were notified of the skin issues, they did not follow nursing guidelines for skin integrity. For example, nursing staff did not complete and/or document a revised Braden Scale in IView. In addition, based on records provided, nursing staff did not appear to conduct a full head-to-toe skin assessment to assess for other possible skin integrity issues. Moreover, no acute care plan was found for this unstageable pressure ulcer to Individual #221's left wrist. Of note, documentation indicated that the extent of tissue damage within the ulcer could not be confirmed, because it was obscured by slough or eschar. If slough or eschar was removed, a Stage III or IV pressure injury was likely.

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	170	120	235	46	584	59	62	188	221
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Significant work is needed to improve the nursing interventions included in IHCPs.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.	
Summary: Since the last review, the scores during this review showed some improvement with regard to timely referral of individuals to the PNMT. The Center should focus on continuing to improve its progress in this area, as well as improving referral of all individuals that meet criteria for PNMT review and timely completion of the PNMT initial review, completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT comprehensive assessments.	Individuals:

#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	57% 4/7	1/1	N/A	N/A	1/2	0/1	0/1	1/1	N/A	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	43% 3/7	0/1			0/2	0/1	1/1	1/1		1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/5	N/A			0/2	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.	43% 3/7	1/1			0/2	0/1	1/1	0/1		1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	0% 0/2	N/A			0/1	N/A	N/A	N/A		0/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	14% 1/7	0/1			0/2	0/1	0/1	1/1		0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • 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	N/A	N/A	N/A		0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5	N/A			0/2	0/1	0/1	0/1		N/A

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

- When Individual #170's IDT referred him to the PNMT on 2/22/17, he had experienced six falls in just over 30 days, with four of these falls in the month of January 2017. Three of these falls occurred in one day within approximately 15 minutes of each other. On 3/1/17, the PNMT conducted a review. The IDT had determined that changes in his Tegretol doses were the root cause of his falls. With little evidence to support this finding, the PNMT essentially concurred, and concluded the IHCP was appropriate. The PNMT reviewed Individual #170's risk ratings, but did not discuss evidence to support the ratings, and documented limited discussion of Individual #170's health and physical status. Despite the theory that changes in Tegretol doses were the underlying cause of his falls, no Pharmacy or Medical Department staff participated in the PNMT's review.
- From 12/29/16 to 1/6/17, Individual #46 was hospitalized for pneumonia. On 1/12/17, a Pneumonia Event Root Cause

Analysis (PERCA) meeting was held. Although the PNMT RN conducted a review, it was not completed timely. More specifically, on 1/6/17, Individual #46 was discharged from the hospital, and on 1/13/17, the PNMT RN conducted a post-hospitalization review. The PNMT RN made a referral to the PNMT for review at that time. However, it was not until 1/19/17 that the PNMT conducted the review. Evidence was not present to show Dietician or PCP involvement in the review. Given that Individual #46 had two aspiration pneumonia events during the course of the year (i.e., 12/29/16, and 2/24/17), it was unclear why the PNMT did not complete a comprehensive assessment.

On 5/6/17, staff identified a wound on Individual #46's popliteal fossa (i.e., knee pit). On 5/8/17, the decubitus was determined to be a Stage III ulcer. On 5/9/17, Individual #46 was referred to the PNMT, but the PNMT did not conduct its review until 5/16/17. No evidence was found of the participation of the PCP or another provider in the review. Given that Individual #46 had not had an evaluation related to skin integrity previously, the PNMT should have conducted a comprehensive assessment.

- On 8/4/16, a modified barium swallow study (MBSS) recommended that Individual #584 have an enteral tube placed. No evidence was presented to show that her IDT referred her to the PNMT at that time. Although it appeared the SLP recommended referral to the PNMT, the list of recommendations in the ISPA did not carry this recommendation forward. The evaluation completed indicated that on 12/21/16, the QIDP made a verbal referral, and on 12/27/16, the QIDP submitted a written referral. On 12/9/16, the IDT held an ISPA meeting to discuss her decline in swallowing ability. On 1/5/17, the most current assessment was completed, which was months after the recommendation for the placement of an enteral tube.
- On 1/18/17, Individual #59's IDT referred her to the PNMT due to weight loss. On 1/19/17, the PNMT completed a review and determined that a comprehensive assessment was indicated. However, her IDT should have referred her or the PNMT should have made a self-referral much sooner. In September 2016, Individual #59 weighed 109.8 pounds with weight loss to 90.1 on 10/12/16, and general continued weight loss through 1/10/17, when she weighed 80.8 pounds. Between 10/3/16 and 10/12/17, Individual #59 was admitted to Austin State Hospital. Reportedly, while there, she refused medications and had poor nutritional intake. On 1/19/17, the PNMT initiated a comprehensive assessment, but did not complete it until 2/24/17. A PCP/provider did not participate in the review. In addition, despite potential contributing factors related to dental and behavioral issues, the PNMT did not involve Dental Department or Behavioral Health Services staff in the assessment process, but rather merely copied assessment information into the PNMT assessment report.
- Between 2/2/17 and 3/8/17, Individual #62 vomited 10 times. On 2/22/17, her IDT referred her to the PNMT for vomiting. On 3/13/17, the PNMT completed its review. The PNMT participated in a "root cause analysis" meeting, and reported the outcome of this meeting in their review. They agreed to complete a chairside evaluation and Head-of-Bed Evaluation (HOBE). They also completed a MBSS. The PNMT indicated they would discharge her when she returned to her baseline of zero episodes of emesis for three consecutive months. It was unclear why the PNMT did not conduct a comprehensive assessment, taking into consideration the root cause analysis information, as well as the other assessments that they agreed to complete. No evidence was found that the PNMT conducted the HOBE.
- On 2/24/17, the PNMT conducted a review of Individual #221's humeral fracture, but this review did not reference the first humeral fracture, which had occurred on 9/16/16. No evidence was found of an RN post-hospital review. Although the PNMT identified potential etiologies of the fracture as Depo-Provera injections and increased agitation and movement, Behavioral Health Services, Pharmacy, and/or a PCP/provider did not participate in the review.

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #46 for pneumonia and skin integrity, and Individual #62). In addition, Individual #584's assessment was completed well after the qualifying event occurred. The following summarizes some of the concerns noted with the assessment that the PNMT completed for Individual #59:

- As noted above, despite potential contributing factors related to dental and behavioral issues, the PNMT did not involve Dental Department or Behavioral Health Services staff in the assessment process, but rather merely copied assessment information into the PNMT assessment report. The PNMT also did not provide findings from a complete physical assessment, discuss current supports and provide data to support findings regarding their effectiveness, and/or recommend goals/objectives and action plans that addressed the etiology of the weight loss.

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 these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.

#	Indicator	Overall Score	Individuals: 170	120	235	46	584	59	62	188	221
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	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 take when they occur, if applicable.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	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: weight, and falls for Individual #170; choking, and fractures for Individual #120; skin integrity, and fractures for Individual #235; aspiration, and skin integrity for Individual #46; circulatory, and aspiration for Individual #584; choking, and weight for Individual #59; skin integrity, and GI problems for Individual #62; choking, and falls for Individual #188; and weight, and fractures for Individual #221.

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

c. All individuals reviewed had PNMPs and/or Dining Plans, and problems were noted with between three and eight components of each PNMP reviewed. Examples of problems included: missing or incomplete lists of risk levels, lack of identification of triggers, missing or incorrect photographs, unclear positioning and/or check and change instructions, lack of positioning instructions for mealtimes and/or oral hygiene/tooth brushing, and incomplete communication instructions.

e. The IHCPs reviewed did not identify the necessary clinical indicators.

f. The IHCPs reviewed did not identify triggers and actions to take should they occur.

g. The IHCPs reviewed did not include the frequency of PNMP monitoring.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	N/A			N/A						
Comments: a. and b. Although Individual #235 is not likely a candidate to move along the continuum to oral intake, in the IRRF, dated 5/17/17, her IDT did not provide clinical justification to show she currently received the least restrictive form of enteral nutrition.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.	
Summary: The Center's performance with regard to the timeliness of OT/PT	Individuals:

assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied, and still requires improvement. Overall, many problems were noted with the quality of the OT/PT comprehensive assessments and updates reviewed. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
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	0/1	1/1	1/1	0/1		0/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	50% 4/8	1/1	0/1	1/1	1/1	0/1		0/1	0/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal	N/A									

	comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/7	0/1	N/A	0/1	0/1	0/1		0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/1	N/A	0/1	N/A	N/A	N/A		N/A	N/A	N/A

Comments: a. and b. The following concerns were noted:

- Following Individual #120's cervical fracture that occurred on 5/2/16, the OT/PT did not complete an update. Subsequently, on 5/15/17, the OT/PT completed an update, which did not meaningfully address the cervical fracture.
- On 10/3/16, the OT/PT completed an update for Individual #584 for her ISP meeting on 10/13/16. On 9/30/15, her last comprehensive evaluation was completed, but it was missing key content related to her functional motor skills, because she was hospitalized at the time of the assessment. That year, the OT/PT did not complete an update to add the missing content. A subsequent update, dated 10/3/16, did not provide a thorough description of her functional motor skills, and did not sufficiently address changes since the previous evaluation. Given that she did not have a complete comprehensive OT/PT assessment, one should have been completed for her.
- On 12/1/16, the OT/PT completed an update for Individual #62's ISP meeting on 12/15/16. However, her last comprehensive assessment was completed in 2013. She was due for another comprehensive assessment, and justification for not providing one was not found.
- Based on the reported decline in Individual #188's functional status, it was unclear why the OT/PT completed an update as opposed to a comprehensive assessment.

d. As discussed above, a number of individuals should have had comprehensive assessments, but did not (i.e., Individual #584, Individual #62, and Individual #188). Overall, many problems were noted with the four OT/PT assessments reviewed. The following summarizes some of the problems noted:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs: For Individual #170, the OT/PT listed diagnoses in last year and how they might impact function, but provided limited to no discussion of their actual relevance to the individual's functional performance or support needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services: For most of the assessments reviewed, individuals' preferences were not reflected in the development of skills;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: The assessments reviewed lacked rationale for risks levels in relation to OT/PT supports, and for one individual, this section was omitted;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For most assessments reviewed, the assessors did not discuss whether or not medications were potentially impacting an OT/PT problem(s);
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): For Individual #46, discussion of working condition was not included in the assessment;
- 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: Two of the assessments reviewed did not provide a complete comparative analysis;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: None of the assessments met this criterion. Problems included a lack of monitoring findings, and/or a lack of discussion about the effectiveness of supports;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: A number of assessments identified OT and/or PT needs for which supports or services were not recommended, but clinical justification was not offered for not making such recommendations. Similarly, some assessments recommended services, but did not provide the rationale. The only assessment that met criterion was the one for Individual #235; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations that should have been made to address individuals' needs were not.

On a positive note, as applicable, the assessments reviewed provided:
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living.

e. The following summaries some examples of concerns noted with regard to the required components of the OT/PT assessment for Individual #120:
- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs: The OT/PT did not discuss the impact of her cervical fracture on her functional status in comparison with findings from the previous assessment;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: The update did not discuss the circumstances around her cervical fracture, and the impact on her risk moving forward;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: Beyond swallowing function, the update provided limited discussion of the impact of medications on OT/PT supports, and/or failed to identify whether or not the individual experienced potential side effects;
- 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: The OT/PT did not discuss the impact of her cervical fracture on her functional status in comparison with findings from the previous assessment, and did not provide specific data related to her OT/PT direct therapy goals;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Because of the lack of data related to goals/objectives, the update did not include evidence regarding progress, maintenance, or regression;
- 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: Based on other documentation reviewed, Individual #120 had not shown improvement with direct PT services. However, according to the discharge ISPA, the PT recommended a consult related to cervical range of motion (ROM) restrictions with consideration to resume therapy after completion. No discussion of this was noted in the update; 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: As noted above, the update did not include recommendations to address a consult related to cervical ROM, and resumption of direct PT. In addition,

recommendations were not offered related to possible edema.

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

- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; and
- 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).

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: Overall, individuals' ISPs did not reflect their functional status from an OT/PT perspective, including strengths and needs, and did not reflect IDT discussion about changes needed to PNMPs. In addition, action plans in ISPs and/or ISPAs did not include recommended interventions.

#	Indicator	Overall Score	Individuals: 170	120	235	46	584	59	62	188	221
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	13% 1/8	0/1	0/1	1/1	0/1	0/1	N/R	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	38% 3/8	0/1	0/1	0/1	0/1	1/1		1/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/8	0/1	0/1	0/2	N/A	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.	20% 1/5	N/A	0/1	1/2	0/1	N/A		N/A	N/A	0/1

Comments: a. through d. Overall, individuals' ISPs did not reflect their functional status, including strengths and needs, and did not reflect IDT discussion about changes needed to PNMPs. In addition, action plans in ISPs and/or ISPAs did not include recommended interventions.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
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					N/R				
	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.	13% 1/8	0/1	0/1	0/1	0/1		1/1	0/1	0/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and	0% 0/3	0/1	0/1	N/A	N/A		0/1	N/A	N/A	N/A

	• Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/4	N/A	0/1	N/A	N/A		N/A	0/1	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/3	N/A	N/A	0/1	0/1		0/1	N/A	N/A	N/A

Comments: Individual #584 had functional communication skills and was part of the outcome group, so these indicators were not reviewed for her.

a. through c. The following provides information about problems noted:

- Individual #170's 2014 and 2015 screenings did not meet criteria. As a result, it was not clear whether or not additional assessment was needed. For example, missing components in the screenings included findings from the Speech Language Pathologist's (SLP's) direct observations of the individual, or comments on prescribed medications.
- Similarly, Individual #120's 2015 screening did not meet criteria. For example, the screening did not sufficiently address pertinent diagnoses, vision, hearing, or medications. She used verbal communication, but was somewhat unintelligible to an unfamiliar communication partner. Individual #120 should have had an assessment to document exploration of AAC to expand her existing communication skills. She scored 75% on her screening, and so the SLP concluded that supports were effective. However, the basis was unclear for the scoring as well as the designation of 75% as the score that indicated the current level of supports was effective. Moreover, based on her Communication Dictionary, it appeared she has fewer communication skills than described in the screening, dated 1/16/15.
- Individual #235's last comprehensive assessment, dated 11/25/15, recommended annual reassessment. On 2/22/16, the IDT met to addend this assessment. This ISPA stated that due to changes in the Monitoring Team's audit tool guidelines, the SLP would complete an update for Individual #235 every three ISP years. This is not an accurate interpretation of the audit tool guidelines, which state: "…On at least an annual basis, if an individual is receiving any type of formal communication service, including direct speech therapy/treatment or communication SAPs, the individual receives an annual update that includes objective indicators… For individuals receiving direct or indirect communication supports, a comprehensive assessment is completed as recommended by the SLP, but at a minimum of every three years, a determination is made as to whether a comprehensive assessment is needed. Such a determination should include a statement justifying the need or lack thereof for a comprehensive assessment…" The ISPA did not provide justification for not completing an update annually for Individual #235. The three-year reassessment option needs to be individualized, and any decisions to modify the comprehensive assessment or annual update schedule needs to be clearly consistent with the individual's needs.
    - This same concern was noted for Individual #62, and for Individual #188.
- Individual #46's most current comprehensive was completed on 11/10/15. The SLP and/or IDT provided no explanation of why a more recent assessment was not completed for this individual who had had regression in his communication skills due to a cerebral vascular accident (CVA).
- In 2012, Individual #59 was admitted to Lufkin SSLC at age 11, and on 12/18/12, an SLP completed a screening. The screening identified her as being a high priority for completion of a comprehensive evaluation, because she did not communicate verbally and had behavioral concerns. It was also reported that she came to Lufkin SSLC knowing over two hundred signs. The SLP decided that it was not a good time to complete an evaluation, because Individual #59 needed time to acclimate to her new

environment. This was questionable clinically, because it would have been important to obtain baseline measures. Individual #59 received direct therapy, and a communication book, but it did not appear that the SLP completed an assessment until 11/26/13. It was unclear whether this was an update or a comprehensive evaluation. This assessment recommended a 90-day trial of direct therapy. The update, dated 12/1/14, discontinued direct therapy due to a lack of consistent and measurable success, and recommended annual updates. No evidence was found of an assessment in 2015, and no ISPA was found providing a reason for the lack of an assessment. An update, completed on 11/16/16, stated Individual #59 had a picture schedule and community picture board. It also noted that the communication book was "used as a weapon." It was unclear why Individual #59 did not have a comprehensive assessment in 2016. As discussed below, the most recent assessment was poor.

- For Individual #221, the Center did not submit an update, and/or evidence that the SLP completed a comprehensive evaluation.

d. and e. As noted above, a number of individuals reviewed had not had needed communication assessments. The following describes some of the concerns with the communication update completed for Individual #59:

- The individual's preferences and strengths are used in the development of communication supports and services: Reportedly, one of Individual #59's strengths was the ability to use more than 200 signs. Her most recent update did not incorporate this strength into recommendations designed to expand her ability to communicate;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: The update did not provide a complete description of her expressive and/or receptive language skills;
- The effectiveness of current supports, including monitoring findings: The assessment did not include monitoring findings, and did not address staff's concerns that Individual #59 required prompts to use her AAC device, or used it when she "wanted to;"
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: The update did not provide evidence of a current review, but rather reported that Individual #59 used a previous AAC device as a weapon. It was not clear that the SLP interacted with her or made specific observations. The update did not address Individual #59's current American Sign Language (ASL) vocabulary and how this compared to her 200 plus signs present upon admission and the previous evaluation; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: The update offered no communication recommendations for this teen-ager with identified communication strengths and needs.

On a positive note, the update provided:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication; and
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

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: Although many of the individuals reviewed likely should have had communication strategies included in their ISPs, the lack of current and/or quality communication assessments made it impossible to determine which clinically relevant supports should have been included in their ISPs. This is an area that requires significant effort to correct. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 170	120	235	46	584	59	62	188	221
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.	38% 3/8	0/1	0/1	1/1	1/1	N/R	0/1	0/1	1/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/7	N/A	0/1	0/1	0/1		0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. Problems varied with regard to the descriptions in individuals' ISPs of their communication abilities, and how staff should communicate with them. In some cases, ISPs did not provide complete descriptions of what staff needed to do to communicate effectively with the individuals. In other cases, ISPs provided limited descriptions of individuals' functional skills. Of significant concern, Individual #59 reportedly knew more than 200 signs upon her admission to Lufkin SSLC. Her ISP did not include a description of her signing ability, although it did reference use of a picture schedule and poster.

b. Statements in ISPs that IDTs had "approved" and/or "updated" Communication Dictionaries appeared to simply be rote statements that were not individualized, particularly because other documentation the Center submitted indicated some individuals did not have Communication Dictionaries (e.g., Individual #235, and Individual #221), but their ISPs included these statements.

c. Although many of the individuals reviewed likely should have had communication strategies included in their ISPs, the lack of current and/or quality communication assessments made it impossible to determine which clinically relevant supports should have been included in their ISPs. This is an area that requires significant effort to correct.

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: SAP measurability has steadily improved over the past three reviews. With sustained high performance, the related indicator (2) might be moved to the category of requiring le oversight after the next review. The other indicators remained at about the same level of performance. They will all remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
2	The SAPs are measurable.	100% 23/23	2/2	3/3	2/2	2/2	3/3	3/3	3/3	3/3	2/2
3	The individual's SAPs were based on assessment results.	78% 18/23	1/2	3/3	2/2	1/2	3/3	2/3	3/3	3/3	0/2
4	SAPs are practical, functional, and meaningful.	61% 14/23	0/2	3/3	2/2	0/2	3/3	1/3	3/3	2/3	0/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/23	0/2	0/3	0/2	0/2	0/3	0/3	0/3	0/3	0/2

Comments:
The Monitoring Team chooses three current SAPs for each individual for review. There were only two SAPs to review for Individual #3, Individual #237, Individual #517, and Individual #279, for a total of 23 SAPs for this review. Although indicator 1 was in the category of requiring less oversight, these individuals could have benefited from more skills training. It is likely that two SAPs did not reflect their needs.

3. Seventy-eight percent of the SAPs were based on assessment results. The remaining five SAPs were inconsistent with assessment results. For example, Individual #3 had a SAP to learn to track his money in a ledger, however, his functional skills assessment indicated that he was independent in tracking his money using a checking and savings account.

4. Fourteen SAPs were practical, functional, and consistent with their ISP (e.g., Individual #120's make coffee SAP). The SAPs that were judged not to be practical or functional typically represented a compliance issue rather than a new skill (e.g., Individual #415's state appropriate reactions to adverse situations SAP), had assessment data that indicated the individual already possessed the skill (e.g., Individual #415's state his telephone number and address SAP), or was not clearly related to ISP goals (e.g., Individual #237 state the normal range of blood pressure).

5. None of the SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data). It was encouraging to learn that Lufkin SSLC recently established a plan to conduct IOA on every SAP at least every six months. Ensuring the reliability of SAP data should be a priority for Lufkin SSLC.

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

Summary: These assessments were current for all individuals for this review and for the previous two reviews, too, with one exception in January 2016. Therefore, indicator 10 will be moved to the category of requiring less oversight. The other two indicators, regarding availability to the IDT and inclusion of SAP recommendations, showed decreased performance and will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
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.	67% 6/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:

11. Individual #120 and Individual #3's FSAs were not available to the IDT at least 10 days prior to the ISP. Individual #170's FSA and vocational assessment were not available to the IDT at least 10 days prior to the ISP.

12. Individual #3 and Individual #517's vocational assessments did not include recommendations for SAPs.

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

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the last review, 20 of these indicators were moved to the category of requiring less oversight. For this review, six other indicators were added to this category, in restraints, psychiatry, behavioral health, and pharmacy. Two indicators in psychiatry, however, were moved back into active monitoring.

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

Goals/Objectives and Review of Progress

In restraint management, regarding occurrences of more than three crisis intervention restraints within any rolling 30-day period, the indicators regarding IDT discussion of variables that might have impacted the occurrence of behaviors that lead to restraint were not occurring. At this point, Lufkin SSLC should be meeting criteria for all of these indicators for all individuals.

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

Two individuals met psychology/behavioral health outcomes 1 and 2 (indicators 1-9) and, therefore, a deeper review was not done for them, meaning that none of the remaining indicators in psychology/behavioral health were scored for them.

Psychiatry quarterly reviews were missing some components, most commonly, a review of the implementation of non-pharmacological interventions, the attendance sign in sheet, and the MOSES/DISCUS results.

Polypharmacy management was not meeting criteria and two of the indicators were moved back into active monitoring. Individuals who met criteria for polypharmacy were not identified as such.

Acute Illnesses/Occurrences

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

From a medical perspective, numerous problems were noted with regard to the Center's handling of acute issues addressed at the Center, as well as for acute issues requiring ED visits or hospitalizations.

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 but one of the individuals. Emergency/urgent clinics were available for all individuals as needed. The side effect assessments were being conducted, which was good to see, however, the required timeliness of review was not meeting criteria.

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.

Substantially more work is needed to ensure that medical assessments, tests, and evaluations consistent with current standards of care are completed, and PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to address individuals' chronic and at-risk conditions. These treatments, interventions, and strategies need to be included in IHCPs, which were overall lacking a full set of action steps to address individuals' medical needs. PCPs need to implement such action steps timely and thoroughly.

Although it appeared that PCPs were reviewing consultation reports, IPNs did not summarize the substance of the consults or include the recommendations, so it was unclear to what PCPs were agreeing or disagreeing. In addition, for some consultations, PCPs did not make referrals to IDTs, when their input would have been important.

The Center should 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.

The Dental Department should focus on providing timely prophylactic care as well as fluoride treatment, and developing and implementing plans to address individuals' periodontal disease with the assistance of residential staff.

Based on the individuals reviewed, practitioners reviewed Quarterly Drug Regimen Reviews (QDRRs) timely. As a result, the related indicator will be placed in the category requiring less oversight. Improvement is needed with the quality of the QDRRs, particularly with regard to lab monitoring and review of new generation antipsychotic use.

There was good collaboration between psychiatry and behavioral health for all but one individual. Psychiatry-neurology collaboration, however, will need attention given the two new psychiatric providers. Previously, a neuro-psychiatry clinic was a regular part of the psychiatry department activities and should be re-instated.

In behavioral health, Lufkin SSLC had good reliable data for four of the individuals. This was good to see and three of them were making progress. The data collection system checks for reliability of data collection timeliness, IOA, and treatment integrity were in place for some time now. The data collection system for the one individual who had more complex medical and physical needs did not meet criteria for adequacy. Staff training on PBSPs had steadily improved over the past three reviews.

Based on the Monitoring Team's observations, proper fit was potentially an issue for approximately half of the individuals observed.

Based on observations, there were still numerous instances (45% of 75 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

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: This outcome and its indicators applied to five individuals. Two indicators showed sustained high performance for this review and the last two reviews, too, and, therefore, will be moved to the category of requiring less oversight (27 and 28). Overall, however, the protections that flow from these indicators were not being met for the important indicators regarding IDT discussion and determination of actions, based upon consideration of a number of variables that might have impacted the occurrence of behaviors that lead to restraint. These are indicators 20 through 23. At this point, Lufkin SSLC should be meeting criteria for all of these indicators for all individuals. These other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	401	415	19	170				
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10	80% 4/5	0/1	1/1	1/1	1/1	1/1				

	business days of the fourth restraint.										
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.	80% 4/5	0/1	1/1	1/1	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.	20% 1/5	0/1	1/1	0/1	0/1	0/1				
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/5	0/1	0/1	0/1	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?	20% 1/5	0/1	1/1	0/1	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.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 5/5	1/1	1/1	1/1	1/1	1/1				
26	The PBSP was complete.	N/A	N/A	N/A	N/A	N/A	N/A				
27	The crisis intervention plan was complete.	100% 5/5	1/1	1/1	1/1	1/1	1/1				
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 5/5	1/1	1/1	1/1	1/1	1/1				
29	If the individual was placed in crisis intervention restraint more than	0%	0/1	0/1	0/1	0/1	0/1				

	three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	0/5									

Comments:
18-29. This outcome and its indicators applied to Individual #279, Individual #401, Individual #415, Individual #19, and Individual #170.

18-19. Individual #401, Individual #415, Individual #19, and Individual #170 had an ISPA to address their restraints within 10 business days of their fourth restraint. Additionally, a sufficient number of ISPAs existed for developing and evaluating their plan to address each individual's restraints. Individual #279's IDT met on 3/2/17 to review restraints that occurred on 1/25/17, 1/26/17, and 2/24/17, however, there was no evidence of an ISPA to address his four restraints in 30 days that occurred on 3/24/17 (restraints on 2/24/17, 3/3/24, 3/3/17, 3/24/17).

20. Individual #401's ISPA following more than three restraints in 30 days included a discussion of potential adaptive skills, and biological, medical, and/or psychosocial issues, and actions to address them in the future. This was good to see.

Individual #415, Individual #19, and Individual #170's ISPAs included discussions of their Medical/Psychiatric/Psychosocial status, however, it was not clear if the IDT hypothesized that these variables affected the dangerous behaviors that provoked their restraints. Individual #279 did not have an ISPA that addressed more than three restraints in 30 days.

21. None of the individuals ISPAs following more than three restraints in 30 days reflected a discussion of potential contributing environmental variables. Individual #279 did not have an ISPA that addressed more than three restraints in 30 days.

22. Individual #401's ISPA included a discussion of potential antecedent events that affected her restraints (i.e., being asked to leave the unit at an unscheduled time), and a plan to address it (i.e., warn Individual #401 prior to unscheduled changes). This, too, was good to see.

Individual #170's ISPA included discussions of various antecedent events to his restraints, however, it was not clear if the IDT hypothesized that these variables affected the dangerous behaviors that provoked his restraints. Individual #415 and Individual #19's ISPA did not discuss antecedent events. Individual #279 did not have an ISPA that addressed more than three restraints in 30 days.

23. Individual #415's ISPA indicated that his IDT discussed potential consequences that may have affected his dangerous behavior that provoked his restraint, however, no actions to address them was documented in his ISPA. Individual #401, Individual #19, and Individual #170's ISPAs following more than three restraints in 30 days did not reflect a discussion of potential consequences or maintaining variables of the dangerous behaviors that provoked their restraint. Individual #279 did not have an ISPA that addressed more than three restraints in 30 days.

29. None of the individuals ISPAs following more than three restraints in 30 days reflected a discussion of an IDT review of the PBSP.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary:			Individuals:								
#	Indicator	Overall Score									
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.										
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.										
Comments:											

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledged that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all but one of the individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
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	0/1	0/1	N/A
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	0/1	0/1	N/A
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
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) were developed and implemented.											

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Good performance was demonstrated and criteria were met for all but one individual. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
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.	88% 7/8	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	N/A
24	The psychiatrist participated in the development of the PBSP.	88% 7/8	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	N/A

Comments:
23. The psychiatric documentation referenced specific behaviors that were being tracked by behavioral health. The psychiatrist attempted to correlate the behavioral health target behaviors to the diagnosis. In addition, the functional assessment included information regarding the individual's psychiatric diagnosis and included the effects of said diagnosis on the target behaviors.

Criteria were met for all but one individual. This individual was a new admission who had complicated behavioral and psychiatric disorders. Psychiatry documentation did not show review of suicidal ideation, flight, property destruction, verbal aggression, disruptive behavior, or attention seeking behavior in the CPE.

24. There was documentation of the psychiatrist's review of the PBSP in the psychiatric 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: As noted below, psychiatry-neurology collaboration will likely need attention given the two new psychiatric providers. Previously, a neuro-psychiatry clinic was a regular part of the psychiatry department activities and should be re-instated. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	67% 2/3	N/A	1/1	1/1	N/A	0/1	N/A	N/A	N/A	N/A
26	Frequency was at least annual.	100% 3/3	N/A	1/1	1/1	N/A	1/1	N/A	N/A	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	33% 1/3	N/A	0/1	1/1	N/A	0/1	N/A	N/A	N/A	N/A

Comments:
25-27. These indicators applied to three individuals. Previously, there was a functioning neuro-psych clinic at this facility. The review of clinical documentation provided for this monitoring visit did not indicate that this clinic was functioning as it had previously. For example, in the record regarding Individual #401, there was psychiatric documentation indicating that while she was prescribed Depakote, due to a diagnosis of a seizure disorder, this medication was being utilized for a dual purpose by psychiatry. In addition, the record indicated that neurology would be responsible for managing this medication. Individual #401 saw the neurologist in January 2017, and the neurologist recommended that Depakote be dosed twice daily. Individual #401 was subsequently evaluated by psychiatry and the dosage of Depakote was increased and the dosage schedule changed to once daily in the absence of neurology consultation. It should be noted that this dosage/schedule alteration was performed by a psychiatry provider who was new to the facility and may be unfamiliar with the need for interdisciplinary consultation.

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

Summary: Not all of the required content of the quarter psychiatry reviews was included in the documentation. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 279	120	517	237	401	415	19	170	3
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
35	The individual's psychiatric clinic, as observed, included the standard components.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
33. Although this indicator was moved to the category of requiring less oversight, two individuals did not have quarterly reviews completed on time (Individual #415, Individual #517).

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing two to four components; most commonly, a review of the implementation of non-pharmacological interventions recommended by the psychiatrist and approved by the IDT, the attendance sign in sheet, and the MOSES/DISCUS results. While the MOSES/DISCUS scores were generally included, the date of the assessment was not designated, so it was not possible to determine what assessment was utilized.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.

Summary: The scoring for this indicator was the same as for the last review, too. The assessments were being conducted, which was good to see, however, the required timeliness of review was not meeting criteria. This indicator will remain in active monitoring.

#	Indicator	Overall	Individuals: 279	120	517	237	401	415	19	170	3

		Score									
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	25% 2/8	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1	N/A

Comments:
36. There were delays in the review of the some of the assessments by the prescribing practitioner in the records regarding Individual #401, Individual #415, Individual #279, Individual #237, Individual #19, and Individual #517.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.

Summary: Emergency/urgent clinics were available for all individuals as needed. This was also the case for all individuals for the last two reviews, too. Therefore, indicator 37 will be moved to the category of requiring less oversight. The other two indicators showed improved, which was also good to see. They will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 5/5	N/A	N/A	N/A	1/1	1/1	1/1	1/1	1/1	N/A
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 5/5	N/A	N/A	N/A	1/1	1/1	1/1	1/1	1/1	N/A
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	60% 3/5	N/A	N/A	N/A	1/1	1/1	0/1	0/1	1/1	N/A

Comments:
37-38. Emergency/interim clinics were available to individuals and there was documentation of emergency/interim clinics occurring.

39. There were some examples of inadequate documentation for emergency/urgent or follow-up/interim clinics. For example, Individual #415's records contained a notation regarding the initiation of a new medication. There was no additional information included. The documentation issues may be the result of the transition to a new provider who is not familiar with the system and with documentation requirements.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.

Summary: These important indicators remained at, or improved to, 100%. They will remain in active monitoring for future review. Lufkin SSLC did not utilize PEMA.

			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
40	Daily medications indicate dosages not so excessive as to suggest goal	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A

	of sedation.	8/8									
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Comments:										

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary: Polypharmacy management, including documentation and also the operation of polypharmacy committee reviews, needs attention to meet and maintain criteria. Indicator 46 will remain in active monitoring. Individuals who met criteria for polypharmacy were not identified as such. Therefore, indicators 44 and 45 will be move back to active monitoring.			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
45	There is a tapering plan, or rationale for why not.										
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.	33% 1/3	N/A	N/A	N/A	0/1	N/A	N/A	0/1	1/1	N/A

Comments:

44-45. Although moved to the category of requiring less oversight, polypharmacy was not identified for Individual #401 and Individual #19. That is, as a result, polypharmacy management protections were not applied to them.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for one individual selected by the Monitoring Team meeting criteria for polypharmacy. Polypharmacy meeting was observed during the monitoring visit. This meeting, while well intended, was not a facility level review of the polypharmacy regimens, but rather a case review attended by the individual's IDT members. The need to ensure that this is a facility level review of the regimen with presentation of the justification for polypharmacy was discussed with the psychiatry clinic staff during the monitoring visit.

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 four of the individuals. This was good to see and three of them were making progress. Moreover, given that two of these three individuals met criteria for all indicators for outcomes 1 and 2 in psychology/ behavioral health, a deeper review will not be conducted for them (i.e., none of the remaining indicators in psychology/behavioral health are scored in this report for Individual #120 and Individual #3). Indicator 7 also improved to 100% for this review, for the first time. Indicators 6 and 7 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
6	The individual is making expected progress	33% 3/9	0/1	1/1	0/1	1/1	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.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
9	Activity and/or revisions to treatment were implemented.										
Comments: 6. Individual #120, Individual #237, and Individual #3 were making progress toward their target behavior objectives. Individual #170 appeared to be progressing, however, he was scored as a 0 because his PBSP data were not demonstrated to be reliable (see indicator 5). The remaining individuals were judged to not be making progress. 7. Individual #120 and Individual #3 achieved PBSP objectives and their progress notes documented that new objectives were established.											

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: Continued progress was demonstrated. Across this review and the previous two reviews, scoring has steadily increased, from 14% to 44% to 71%. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	71% 5/7	0/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	N/A

17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	

Comments:
16. Individual #237, Individual #401, Individual #19, Individual #415, and Individual #170 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:

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

Comments:

Outcome 8 – Data are collected correctly and reliably.

Summary: The data collection system checks for reliability of data collection timeliness, IOA, and treatment integrity were in place at Lufkin SSLC for some time now (i.e., 100% scores for this review and the last two reviews, too). Therefore, indicators 28 and 29 will be moved to the category of requiring less oversight. The other three indicators will remain in active monitoring. The data collection system for the one individual who had more complex medical and physical needs did not meet criteria for indicators 26 and 27.

#	Indicator	Overall	Individuals: 279	120	517	237	401	415	19	170	3

		Score									
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	86% 6/7	1/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	N/A
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	86% 6/7	1/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	N/A
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A
30	If the individual has a PBSP, goal frequencies and levels are achieved.	14% 1/7	1/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	N/A

Comments:
26-27. The data collection system for target and replacement behaviors for the majority of individuals was flexible and adequately measured PBSP and replacement behaviors across all treatment sites. The exception was Individual #517's data collection system that only required staff to record data once a shift. This system did not encourage regular data collection, and would not likely provide an adequate measurement of behaviors that occur at high rates.

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 #279. Individual #517 did not have a treatment integrity assessment in the last six months. Individual #237's IOA and DCT levels were below 80%. Individual #401, Individual #415, and Individual #19's DCT levels were below 80%. Finally, Individual #170's IOA level was below 80%. Ensuring that the established frequency and levels of IOA, data collection timeliness, and treatment integrity are consistently achieved 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 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	170	120	235	46	584	59	62	188	221

		Score									
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 #170 – other: hypothyroidism, and other: hypertension; Individual #120 – fractures (i.e., cervical spine fracture), and seizures; Individual #235 – respiratory compromise, and seizures; Individual #46 – constipation/bowel obstruction, and other: hypothyroidism; Individual #584 – respiratory compromise, and polypharmacy/side effects; Individual #59 – cardiac disease, and GI problems; Individual #62 – diabetes, and cardiac disease; Individual #188 – respiratory compromise, and cardiac disease; and Individual #221 – osteoporosis, and weight].. None of the goals/objectives reviewed were clinically relevant, achievable, and/or measurable.

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

Outcome 4 – Individuals receive preventative care.											
Summary: Three of the nine individuals reviewed received the preventative care they needed. 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 Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221

a.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	60% 3/5	N/A	0/1	0/1	1/1	1/1	N/A	1/1	N/A	N/A
	iii. Breast cancer screening	75% 3/4	N/A	1/1	0/1	N/A	1/1	N/A	1/1	N/A	N/A
	iv. Vision screen	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	88% 7/8	1/1	1/1	0/1	1/1	1/1	N/A	1/1	1/1	1/1
	vii. Cervical cancer screening	20% 1/5	N/A	1/1	0/1	N/A	0/1	N/A	0/1	N/A	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. The following problems were noted:

- Based on the two documents provided, Individual #170's immunization status was not clear.
- For Individual #120, no colonoscopy report or fecal occult blood DNA testing report was submitted.
- Much of Individual #235's preventative care was overdue, including a colonoscopy that was last done in 2005, a mammogram that was last done in 2011, a vision screening that was last done in 2012, and no record of a pap smear or DEXA scan. As discussed below, Individual #235 had a DNR in place, but this should not have resulted in a suspension of preventative care.
- Individual #584 had not had a Prevnar 13 vaccination. In addition, there was no documentation of cervical cancer screening. However, her AMA stated that a pelvic ultrasound report indicated "further evaluation with hysteroscopy and/or potentially endometrial bx [biopsy] is recommended if there is a history of vaginal bleeding or suspicion of endometrial carcinoma." The reason for this comment was not clear.
- For Individual #62, cervical cancer screening said "N/A," but the PCP provided no explanation.
- For Individual #221, no cervical cancer screening was documented, and her last eye evaluation occurred in 2014 for an acute issue.

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: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
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% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. On 6/3/15, Individual #235's DNR was signed, and the PCP made a four-line IPN entry stating the justification for the DNR was family request. This entry did not offer clinical justification consistent with State Office policy for the DNR, and it did not appear annual review including providing renewed justification had occurred. Since the signing of the DNR two years ago, most of Individual #235's preventive care appeared to have been suspended. A DNR does not mean do not treat. Center staff should take steps immediately to address these issues.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Numerous problems were noted with regard to the Center's handling of acute issues addressed at the Center, as well as for acute issues requiring ED visits or hospitalizations. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
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% 1/15	0/2	0/1	1/2	0/1	0/2	0/1	0/2	0/2	0/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	13% 2/15	0/2	0/1	1/2	0/1	0/2	0/1	1/2	0/2	0/2
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	14% 1/7	N/A	N/A	N/A	1/2	0/1	0/1	N/A	0/2	0/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary	40%				1/1	0/1	1/1		0/2	N/A

	admission, the individual has a quality assessment documented in the IPN.	2/5									
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.	100% 7/7				2/2	1/1	1/1		2/2	1/1
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	80% 4/5				2/2	N/A	0/1		1/1	1/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	17% 1/6				1/2	N/A	0/1		0/2	0/1

Comments: a. and b. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 15 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #170 (fall on 3/18/17, and fall with multiple injuries on 4/15/17), Individual #120 (muscle spasm on 1/30/17), Individual #235 [diarrhea and Clostridium difficile (C. Diff) infection on 4/11/17, and wheezing on 5/3/17], Individual #46 (multiple pressure ulcers on 5/5/17), Individual #584 [urinary tract infection (UTI) and functional decline on 12/12/16, and increased seizures on 12/1/16], Individual #59 (ear discharge on 2/3/17), Individual #62 (pressure ulcers on 2/23/17, and headache/pain on 3/7/17), Individual #188 (right jaw furuncle on 5/9/17, and eye infection on 6/5/17), and Individual #221 (abnormal EKG on 2/23/17, and eye infection on 4/20/17).

The acute illness for which documentation was present to show that the medical provider assessed the individual according to accepted clinical practice was for Individual #235 (wheezing on 5/3/17).

The acute illnesses/occurrences 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 included those for Individual #235 (wheezing on 5/3/17), and Individual #62 (headache/pain on 3/7/17).

The following provide examples of problems noted:

- On 3/18/17, Individual #170's PCP documented that the individual fell in the morning and hit his head: "no neuro findings per RN but seems a little unsteady on his feet." The following physician exam was recorded: "No focal neuro findings. Able to do simple tests of coordination. Can walk but a little ataxic; could partly be due to his lunging style of movement. Some redness L [left] frontally, no break in skin or swelling." According to the Assessment/Plan: "Ataxia. Doubt this is injury related. Staff reports [he] has been having intermittent ataxia for several weeks and now sometimes uses a gait belt." The physical exam did not include a complete neurologic assessment, and the PCP provided no discussion of the etiology or plan related to the ataxia. The PCP documented no further follow-up.

On 4/15/17, nursing staff documented that Individual #170 fell again, and sustained multiple minor injuries, including abrasions to the left palm, left knee, left great toe, and right elbow. He also chipped two front teeth. Per nursing documentation, the PCP was notified and stated: "no need to place him on sick call, refer [sic] to dental is what he needs." On 4/17/17, the dental assessment occurred with the dentist noting: "#8 central incisor showed some potential signs." The recommendation was to put Individual #170 on list for TIVA for more diagnostics and possible treatment. Again, the PCP documented no further follow-up.

- The PCP documented that Individual #120 was seen due to a reported decrease in neck range of motion, since sustaining a neck fracture in May 2016. Documentation of the physical exam was limited and stated that the individual's neck muscles, especially the posterior cervical muscles felt very hard and tense. The plan was to treat the individual for a muscle spasm with "both oral and topical agents (Flexeril and Salonpas) to see if they make a difference." The PCP documented no follow-up on this issue.
- For Individual #235's diarrhea, the PCP's initial assessment was not timely. On 4/11/17, nursing staff noted that the individual had three bowel movements and a skin crack on the coccyx region. On 4/13/17, the PCP documented the history of diarrhea. Examination of the abdomen was unremarkable. The stool was noted to be semi-formed, mixed with a small amount of mucous and very small amount of blood. On 4/17/17, a stool sample was sent for C. diff. testing. The PCP also noted that a superficial linear abrasion was noted on the coccyx (size not noted). On 4/20/17, the PCP documented that the stool sent on 4/17/17 was positive for C. diff. The individual was transferred to the Infirmary and started on a 14-day course of metronidazole. On 4/23/17, another PCP documented that the individual had C. diff. enterocolitis and was on day two of metronidazole. The PCP(s) documented no further follow-up. Of note, three different providers completed the documentation the Monitoring Team reviewed, resulting in a lack of continuity of care. This was an issue for several of the individuals reviewed.
- On 5/5/17, the PCP documented that Individual #46 had a partially avulsed right great toe nail. There was no specific treatment plan for this. The Assessment and Plan portion of the IPN stated: "expect the nail to loosen and eventually come off w/ new nail growing behind it. When it gets too loose perhaps some kerlix or something could be wrapped around tip of toe to prevent nail from catching on something and being torn off."

  On 5/5/17, nursing staff documented two areas of skin concern behind the left knee. On 5/6/17, nursing staff documented numerous areas of skin concerns described as being "irritated with redness noted." On 5/6/17, nursing staff also documented seven wounds, three of which had eschar development and were unstageable. The PCP did not document assessment of any of these multiple wounds. On 5/7/17, nursing staff noted that an initial dose of Keflex was administered. Individual #46 had a Stage III pressure ulcer and multiple unstaged ulcers. However, the PCP did not document an evaluation. After the 5/5/17 note, the next PCP note was on 5/23/17, and was related to a cough.
- On 12/1/16, the PCP documented in a two-line IPN entry that Individual #584's "seizures seem to have been increased lately. Have increased CBZ [carbamazepine] a little. Requesting next Neurology clinic." The PCP did not specify the dosage change. This initial assessment was problematic. There was also no documentation of an assessment that targeted potential causes of the increased seizure frequency, such as infection, sub-therapeutic anti-epileptic drug (AED) levels, compliance with medications, etc. The PCP also did not provide adequate documentation of the individual's current status, such as the most recent labs/drug levels. The rational and/or mechanism for increasing the CBZ dose from 600 mg per day to 1400 mg per day was not clear. Nor was it clear why the Pharmacy would dispense this dose given the most recent AED levels. The PCP did not document any follow-up.

On 12/12/16, the PCP noted that the individual was reported to not be feeling well. A four-line IPN entry was made that included an assessment that stated: "cold symptoms, no fever." The plan was to continue antihistamines. Nursing staff continued to document that the individual did not feel well and could no longer feed herself.

On 12/21/16, the PCP documented a late entry for 12/15/16. It stated: Subjective: "change in mental status, appetite change, will not self-feed per staff." Objective: "A&O [alert and oriented], denies pain at this time, had wet diaper during visit, no abd [abdominal] pain, LCTAB [not a standard abbreviation, but thought to mean lungs clear to auscultation bilaterally], Heart RRR [regular rate and rhythm], afebrile." Assessment: "AMS [altered mental status]. Plan: Checked UA [urinalysis] C&S [culture and sensitivity] 12/15/16; culture showed E. coli; started on nitrofurantoin."

On 12/21/16, the PCP also made a late entry for 12/19/16, and documented that individual was seen for sore throat, urine culture came back, nitrofurantoin discontinued, and Cipro started. The PCP documented the individual's throat was pale, with no erythema, no exudate, and no edema. The assessment was UTI and the plan was to obtain a stat comprehensive metabolic panel and complete blood count. No further follow-up was noted for the UTI. The PCP made an additional IPN entry on 12/21/16 noting that the individual was paced on sick call "for sore throat again." The assessment was "sore throat" and the plan was PRN Tylenol and PRN viscous lidocaine.

On 12/22/16, the neurologist saw Individual #584, and indicated he had seen the individual five months earlier and made the recommendation to continue seizure medications. He noted that: "She is on a changed dose of carbamazepine which I do not truly understand. It appears that she is on 1400mg a day divided over three times a day."

On 12/28/16, another PCP noted that Individual #584 was "noted by staff to have AMS [altered mental status] and declined in ability to self-feed and pivot during transfer; Decline began in the beginning of the month of December. Vital signs were stable but the individual became more lethargic. Patient was screened and treated for UTI (E. coli) with Ciprofloxin. However, she continued to decline in ADLs. Medications were reviewed and it was noted that early in the month when patient had breakthrough seizures carbamazepine was increased from 300mg BID [twice a day] to an additional 400mg BID. Patient's previous labs also showed an elevated VPA [Valproic Acid] level." The PCP also indicated that the RN Case Manager attended clinic "specifically to notify Neurology of the noted decline in patient since the start of additional medication of carbamazepine." It should be noted that the 12/28/16 PCP IPN entry was the first documentation by a PCP regarding an association between the functional decline of the individual and the increase in carbamazepine dose.

The next neurology consult was dated 2/23/17, and stated that the individual was on 1400 mg a day, and apparently since this dose was increased she became more lethargic and less functional. The recommendation was to decrease the CBZ to 1100 mg per day and monitor

There was little continuity of care for Individual #584. On 1/10/17, nursing staff noted that PCP #1 was following the ammonia level due to a functional decline. On 1/6/17, PCP #2 reviewed the ammonia level with no new orders. PCP #3 was scheduled to return on 1/12/17, and would review the labs. On 1/20/17, PCP #3 noted that Gabapentin would be increased

based on neurology recommendations, but there was no comment about the ammonia level.

It is concerning that nursing staff repeatedly documented that Individual #584 had a decline in functional status (i.e., pivoting, feeding, and swallowing), and even noted in the IPNs that recent labs were not available in the record following an increase in CBZ. It is also concerning that the medical staff did not do a thorough review of medications under these circumstances, and that the neurologist was the first to medical provider to comment on the significant increase in the carbamazepine dose.

- On 2/23/17, the PCP documented that Individual #62 was seen for an abrasion to the coccyx area. Two abraded areas surrounded by blanchable red skin were documented. The PCP wrote: "not pressure ulcers but abrasions due to shear." The plan was treat with Medihoney. On 2/26/17, nursing staff documented a blister to Individual #62's right buttock. On 2/27/17, nursing staff documented a Stage I pressure ulcer to the right buttock. On 2/27/17, the Physical Therapist (PT) wrote the following: "She exhibits partial thickness skin loss to the right ischial tuberosity (IT). She was pressure mapped last week and noted some pressure area to bilateral ITs when sitting in scooter… Per staff it started as a blister on Saturday 2/25/17. PT talked to NP [Nurse Practitioner], over the phone about wound care recommendation and she agreed. She also agreed that it is not a stage 1 pressure ulcer but a stage 2 pressure ulcer." There was no PCP documentation of resolution. On 3/14/17, nursing staff documented that the lesions were healed.
- On 3/8/17, Individual #221's PCP documented: "EKG done on 2/23/17 shows an abnormal reading of SVT [supraventricular tachycardia]. It is unknown whether this was real as EKG printout had a lot of artifacts. Will perform a repeat EKG and if the same result is gotten, will then address accordingly." On 3/21/17, one month after the first EKG, the EKG was repeated. The computer interpretation was abnormal EKG due to sinus tachycardia, rightward axis, right antral enlargement, cannot rule out anterior infarct. This EKG was submitted in the IPNs as a lab/radiology review. The PCP made no comments on the abnormal findings, the need for further evaluation, or the need for an over-read by a cardiologist.

  On 3/29/17, the IDT held an ISPA meeting to discuss the abnormal EKG. The PCP was not present. The ISPA documented the Psychiatrist and Clinical Pharmacist's concern related to a QTC interval of 538 milliseconds (ms) and how this might be related to psychotropic medications. The recommendation was to repeat the EKG and refer the individual to cardiology, if needed.

  On 3/30/17, the PCP documented that the EKG was discussed with the psychiatrist and Clinical Pharmacist, and there was no concern about the medications. The plan was to attempt to obtain a repeat EKG and use pre-treatment sedation, if necessary. Individual #221 was referred to cardiology.

c. For five of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #46 (ED visit for cough on 2/1/17, and ED visit for GI bleed on 2/19/17), Individual#584 (hospitalization for aspiration pneumonia on 5/16/17), Individual #59 (ED visit for head trauma on 12/21/16), Individual #188 (ED visit for lip laceration on 3/27/17, and hospitalization for bronchitis on 5/1/17), and Individual #221 (ED visit for elbow fracture).

For Individual #46's ED visit for a cough on 2/1/17, the PCP conducted and documented a timely evaluation prior to the transfer.

d. Two of the acute illnesses reviewed occurred after hours, on a weekend/holiday, or off-grounds, so this indicator did not apply.

Those for whom quality assessments were completed prior to transfer were: Individual #46 (ED visit for cough on 2/1/17), and Individual #59 (ED visit for head trauma on 12/21/16).

e. For the acute illnesses reviewed, it was positive the individuals reviewed received timely treatment at the SSLC.

h. It was concerning that for the individuals reviewed, upon their return to the Center, there often was not evidence 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 following provide examples of problems noted:

- On 5/16/17, nursing staff noted that Individual #584 vomited her medications, was shaking, and possibly had a low oxygen saturation. Because the PCP could not be reached by phone, Individual #584 was scheduled to be seen in the clinic for pitting edema of her feet. At 11:40 a.m., the individual had a blood pressure of 88/50 and was very lethargic. Her oxygen saturation decreased to 89%. An order was given to transport her to the ED. The PCP did not conduct an assessment during normal business hours. The individual was admitted with aspiration pneumonia and hypoxic respiratory failure. She remained hospitalized on 5/31/17. The date of her return to the Center was not clear. The last relevant record was a hospital liaison note, dated 5/30/17.
- On 12/20/16, the PCP documented that Individual #59 was evaluated due to hitting her head, and picking her scalp. The physical exam revealed a deformed right ear with redness and swelling with clear drainage. The left periorbital and temporal regions showed bruising and swelling. The plan was to start oral antibiotics and provide local wound care with follow-up in three to five days if she did not improve.

  On 12/21/16, the PCP wrote that the individual had increasing self-injurious behavior (SIB) and other behaviors indicating pain. Dental staff were consulted and TIVA was not available until January. The individual was referred to the ED for evaluation. X-rays were negative for a fracture and the individual returned to the Center around 6:25 p.m.

  On 12/22/16, the PCP noted that the case was discussed with the Dental Director and the individual would be seen on 12/23/16. On 12/23/16, dental staff documented that the patient arrived for "LR [lower right], UL [upper left], and UR [upper right] scaling and planning." Tooth #3 was extracted "due to being non-restorable tooth."

  The next note from the PCP was dated 12/27/16. This note documented that Individual #59 had one episode of emesis the previous night. This note indicated that "per dental, an abscess was noted to right side of tooth and extracted." This finding was not included in the dental IPN, dated 12/23/17. The plan was to continue antibiotics and pain medication. Neither the PCP nor dentist documented further follow-up.
- On 5/1/17, the PCP documented that Individual #188 was being evaluated for increased nasal drainage. The physical exam was limited to auscultation of the lungs and wheezing was documented. The PCP stated vital signs were stable. As the individual would not remain still, there was no documentation of respiratory rate, heart rate, or oxygen saturation. The assessment was bronchitis and the plan was to continue asthma medications and give five days of prednisone. Less than one hour later, nursing staff documented that the individual was having difficulty breathing and was using accessory muscles to

breath. Individual #188's oxygen saturation was 84% on room air. An order was received to transport the individual to the ED. The PCP did not reassess the individual prior transfer.

The ED physician documented that: "Of note the patient has an enlarged Left eye that is closed and cannot be evaluated. As per state school his eye has been enlarged that way for as long as they remember. They are unable to tell me how long his eye has been swelling that however [sic] he did share that this was a result of self-inflicted trauma."

On 5/4/17, Individual #188 returned to the Center and the PCP saw him. The IPN documented that the diagnosis was influenza and asthma exacerbation. There was no discussion of the eye trauma that the ED notes documented, and/or the CT scans of the orbits that were done. On 5/8/17, in the next note, the PCP stated that the individual was seen for complaints of a swollen eye. The PCP determined this was baseline and the CT scan showed chronic changes

On 6/5/17, nursing staff documented that the individual was prescribed clindamycin for an eyelid infection along with warm compresses.

On 1/11/17, the AMA did note that Individual #188's left eye lid was hyper-pigmented with minor swelling and squinting (blind in this eye).

- On 2/18/17, Individual #221 was sent to the ED and diagnosed with an acute angulated displaced overriding spiral fracture of the distal third of humeral metaphysis. On 3/8/17, the PCP documented: "While on weekend call, I received a call regarding individual from nursing staff on 2/18/17 at 1905." This was the first documentation from the PCP regarding this event.

  On 2/21/17, nursing staff documented that a splint was in place, Individual #221's hand was very swollen, and she was crying. The individual was sent to the ED via physician order for evaluation of the arm. Per nursing notes, the arm was re-wrapped and individual was sent back to the Center. There was no follow-up documentation by a primary care provider regarding the follow-up ED visit or the neurovascular status of the extremity.

  On 2/26/17, the next PCP documentation noted: "individual was seen on sick call today for complaints of a red area at the upper portion of her back." It further stated that the individual sustained a fracture the prior week and the posterior splint was causing the redness. The exam documented no evidence of compartment syndrome.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: Although it appeared that PCPs were reviewing consultation reports, IPNs did not summarize the substance of the consults or include the recommendations, so it was unclear to what PCPs were agreeing or disagreeing. In addition, for some consultations, PCPs did not make referrals to IDTs, when their input would have been important. All of these indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	170	120	235	46	584	59	62	188	221

		Score									
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	0/2	N/A	0/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	100% 16/16	2/2	2/2	2/2	2/2	2/2	2/2	2/2		2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	0/2		0/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	N/R									
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/3	N/A	0/1	N/A	0/1	N/A	N/A	0/1		N/A

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #170 for ophthalmology on 3/1/17, and orthopedics on 1/11/17; Individual #120 for ophthalmology on 2/24/17, and neurology on 4/13/17; Individual #235 for ENT on 5/19/17, and ENT on 2/17/17; Individual #46 for pulmonary on 12/9/16, and hematology on 5/11/17; Individual #584 for gastroenterology (GI) on 2/7/17, and neurology on 2/23/17; Individual #59 for ophthalmology on 5/26/17, and gynecology on 3/1/17; Individual #62 for ENT on 4/21/17, and cardiology on 2/14/17; and Individual #221 for orthopedics on 3/15/17, and orthopedics on 4/18/17.

a. through d. Although it appeared that PCPs were reviewing consultation reports, IPNs did not summarize the substance of the consult or include the recommendations, so it was unclear to what PCPs were agreeing or disagreeing. It is important for PCPs to briefly summarize the consult, as well as the recommendations in IPNs and indicate their agreement or disagreement with each, so that all IDT members are aware of the consultants' recommendations, and the plan moving forward. Because IPNs were incomplete, the Monitoring Team could not determine to which recommendations PCPs had agreed, so could not rate Indicator d.

e. For some consultations, PCPs did not make referrals to IDTs, when their input would have been important.

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

Summary: Substantially more work is needed to ensure that medical assessments, tests, and evaluations consistent with current standards of care are completed, and PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to address individuals' chronic and at-risk conditions. This indicator will remain in active oversight.

Individuals:

#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221

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.	17% 3/18	1/2	0/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review [i.e., Individual #170 – other: hypothyroidism, and other: hypertension; Individual #120 – fractures (i.e., cervical spine fracture), and seizures; Individual #235 – respiratory compromise, and seizures; Individual #46 – constipation/bowel obstruction, and other: hypothyroidism; Individual #584 – respiratory compromise, and polypharmacy/side effects; Individual #59 – cardiac disease, and GI problems; Individual #62 – diabetes, and cardiac disease; Individual #188 – respiratory compromise, and cardiac disease; and Individual #221 – osteoporosis, and weight].

a. For the following individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #170 – other: hypothyroidism, and Individual #235 – respiratory compromise, and seizures. The following summarizes examples of concerns noted:

- Even though the AMA stated a goal for hypertension, it did not include a clear status of the control of Individual #170's hypertension. The AMA should document the assessment (current status) and plan (medical plan) for each active diagnosis. The IRRF, however, documented that his blood pressure was not well controlled. Additionally, the AMA did not discuss target organ status (e.g., evidence of retinopathy, renal disease, heart disease).

  On 3/10/17, the PCP documented that the family requested a thorough cardiovascular assessment. Diagnostics were ordered. On 3/15/17, the PCP documented the data for an atherosclerotic cardiovascular disease (ASCVD) risk score. The note did not specify which tool the PCP used, and the Center did not have a guideline related to determining ASCVD risk. (Given that there are a number of CV risk score tools available, the Center needs medical guidelines to ensure that PCPs utilize the appropriate tools.) Based on the data documented and the comments, it appeared that the PCP used the American Heart Association (AHA)/American College of Cardiology (ACC) tool, and the score was .9%. Individual #170's blood pressure was determined to be "poorly controlled," resulting in the PCP initiating treatment with Lisinopril.

  The statin was discontinued. It should be noted that the ACC/AHA provides a disclaimer stating: "Unfortunately there is insufficient data to reliably predict risk for those less than 40 years of age or greater than 79 years of age and for those with total cholesterol greater than 320." Thus, because Individual #170 was under the age of 40, the decision to discontinue the statin based solely on the ACC/AHA risk score and labs that were obtained while on the statin might not have been appropriate. There was also no discussion of interventions related to metabolic syndrome as per the American Diabetes Association (ADA) guidelines.
- For Individual #120, the PCP provided limited information in the AMA about her cervical spine fracture, and did not list it as an active problem. It was listed as a significant injury (comminuted C1-C2 vertebrae fracture) related to a fall on 5/2/16. The AMA provided no information on fracture management (surgical versus conservative). It also did not provide any information on how this injury impacted Individual #120's ambulation and activities of daily living (ADLs). In the osteoporosis discussion, the IRRF documented that prior to the injury, the individual did minimal ambulation and currently she did not ambulate at all. The cervical spine fracture had impacted several areas of her life, including the individual's ability to receive basic dental treatment at Lufkin SSLC. The PCP should have addressed it as an active problem.

- According to Individual #46's AMA, he was prescribed MiraLax and Senna, and pro re nata (PRN, or as-needed) fleets enemas, and the Dietician was to ensure he had adequate fiber and fluids. He had required multiple enemas, but the PCP had not assessed enema use or changed his bowel management plan.
- On 12/1/16, Individual #584 had an increase in seizure activity. She was prescribed multiple antiepileptic drugs (AEDs). On 12/1/16, the PCP increased the carbamazepine dose from 600 milligrams (mg) daily to 1400 mg daily, but provided no explanation for the specific dose change. No recent drug levels/labs were documented.

  On 12/12/16, 12/15/16, 12/19/16, and 12/21/16, medical providers assessed the individual for numerous complaints, including cold symptoms, a sore throat, inability to self-feed, and decreased appetite. The assessments reviewed did not include any discussion of the change in carbamazepine dose.

  On 12/22/16, the neurologist saw Individual #584, and indicated he had seen the individual five months earlier and made the recommendation to continue seizure medications. He noted that: "She is on a changed dose of carbamazepine which I do not truly understand. It appears that she is on 1400mg a day divided over three times a day."

  On 12/28/16, another PCP noted that Individual #584 was "noted by staff to have AMS [altered mental status] and declined in ability to self-feed and pivot during transfer; Decline began in the beginning of the month of December. Vital signs were stable but the individual became more lethargic. Patient was screened and treated for UTI (E. coli) with Ciprofloxin. She was treated for a UTI. However, she continued to decline in ADLs. Medications were reviewed and it was noted that early in the month when patient had breakthrough seizures carbamazepine was increased from 300mg BID [twice a day] to an additional 400mg BID. Patient's previous labs also showed an elevated VPA [Valproic Acid] level." The PCP also indicated that the RN Case Manager attended the clinic "specifically to notify Neurology of the noted decline in patient since the start of additional medication of carbamazepine." It should be noted that the 12/28/16 PCP IPN entry was the first documentation by a PCP regarding an association between the functional decline of the individual and the increase in carbamazepine dose.

  The next neurology consult was dated 2/23/17, and stated that the individual was on 1400 mg a day, and apparently since this dose was increased she became more lethargic and less functional. The recommendation was to decrease the CBZ to 1100 mg per day and monitor. It should be noted that this consult was requested due to "possible adverse reaction to seizure medications, decreased ADLs since Tegretol increase." Center staff did not report this adverse drug reaction (ADR).
- Individual #59's November 2016 AMA indicated she was prescribed a proton pump inhibitor (PPI) for gastroesophageal reflux disease (GERD) and was asymptomatic with no complaints and no emesis. The PCP's assessment contradicted the IRRF, which reported six episodes of emesis. Moreover, on 12/6/16, a gastroscopy was performed for the indication of emesis. There were no abnormal findings
- Individual #62's AMA stated that on 11/17/16, her A1c was within normal limits. The A1c was actually 5.8, and should have been repeated. If confirmed, the individual would have the diagnoses of prediabetes. The PCP conducted no follow-up for this abnormal lab result. The QDRR, dated 3/10/17, noted the A1c of 5.8 was high, but made no recommendation.
- Individual #62's AMA stated: "According to current guidelines she is not a statin risk category." The PCP did not indicate what guidelines were referenced or if an ASCVD risk score was calculated. The QDRR, dated 3/10/17, documented an ASCVD risk score of 2.7% (the tool used for this calculation was not specified).

The PCP documented that that electrocardiogram (EKG or ECG) was abnormal, and noted that individual had a cardiology evaluation. The PCP did not document the results of the cardiology evaluation. An interim medical review (IMR), dated 10/4/16, simply stated that a cardiology evaluation was done on 6/1/16, for evaluation of a reading of an ECG and to determine if any further work-up was needed. The IMR, dated 3/10/17, noted a cardiology evaluation completed on 2/14/17, for an abnormal EKG, but it provided no specific information.

- Individual #188's AMA indicated his respiratory status would be monitored daily, but provided no description of the monitoring parameters. Currently, he was prescribed Montelukast, Pulmocort, DuoNeb, and ProAir, and according to the AMA, a pulmonologist followed him. Based on a negative smoking history, the etiology of his chronic obstructive pulmonary disease (COPD) diagnosis was unclear. Also, the PCP provided no classification of the stage of his lung disease. The Center did not submit any pulmonary consultations.
- Individual #221 had fractures of both the right (9/16/16) and left humerus (2/18/17). Humeral fractures are usually associated with significant trauma. Risks factors for this type of fracture should be further explored in a young, 28-year-old individual. On 2/4/16, a heel sonogram was obtained, but it is unclear if attempts were made to complete a DEXA scan. This individual had low/normal Vitamin D levels and had a long history of receiving medications that might contribute to bone loss.
- Individual #221 had a history of significant weight loss with the last recorded weight being a few pounds shy of the lower end of her estimated desired weight range (EDWR). The IDT requested that the PCP evaluate this loss, and on 3/8/17, the PCP wrote a note indicating that an 11-pound weight loss occurred and weights would be rechecked in two weeks. The PCP provided no further discussion of this issue, and did not attend the multiple ISPA meetings the IDT conducted to address weight loss.

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. Even for those action steps assigned to the PCPs in IHCPs/ISPs, problems often were noted with implementation. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

#	Indicator	Overall Score	Individuals: 170	120	235	46	584	59	62	188	221
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	28% 5/18	1/2	1/2	2/2	0/2	0/2	1/2	0/2	0/2	0/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. Even for those action steps assigned to the PCPs in IHCPs/ISPs, problems often were noted with implementation.

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	170	120	235	46	584	59	62	188	221
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: a. and b. The 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: It was positive that all of the QDRRs reviewed were timely. Improvement is needed with regard to the quality of the QDRRs, particularly with regard to lab monitoring and review of new generation antipsychotic use. Given the generally timely practitioner review of QDRRs during this review and the past two reviews (Round 9 – 100%, Round 10 – 94%, and Round 11 - 92%), Indicator c will be placed in the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	39% 7/18	0/2	0/2	2/2	0/2	2/2	1/2	0/2	0/2	2/2
	ii. Benzodiazepine use;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2

	iii. Medication polypharmacy;	89% 16/18	2/2	2/2	2/2	0/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	25% 1/4	N/A	N/A	N/A	N/A	N/A	1/2	N/A	N/A	0/2
	v. Anticholinergic burden.	89% 16/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	0/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	89% 16/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	0/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 8/8	2/2	N/A	N/A	N/A	N/A	2/2	N/A	2/2	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 4/4	N/A	N/A	N/A	1/1	2/2	N/A	1/1	N/A	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. It was positive that all of the QDRRs reviewed were timely.

b. Problems varied with regard to lab monitoring. Some examples included:

- For a number of individuals, the Clinical Pharmacist did not comment on or provide recommendations related to abnormal lab values. A few examples include:
  - For Individual #170, the Clinical Pharmacist provided no comments or recommendations related to documented poorly controlled hypertension. Appropriate lab monitoring for hypertension was not documented, nor were ASCVD risks scores documented.
  - Individual #120's 2/17/17 QDRR documented a vitamin D level of 14 from May 2016. For this individual treated for osteoporosis, this was a low value, but the Clinical Pharmacist made no comment or recommendation. It should be noted that this was not the most recent data. A repeat, done on 11/10/16, showed a Vitamin D level of 34, but this information was not included in the QDRR.
  - For Individual #46, the Clinical Pharmacist provided no comment on a markedly elevated serum ferritin of 536.
  - For Individual #62, the Clinical Pharmacist noted that the A1c was elevated at 5.8, and included a list of the blood glucose correlation to HbA1c. There was a statement that the ADA A1c target is less than 7. It should be noted that the A1c target per ADA guidelines is based on age and comorbidities. Furthermore, the ADA specifically states that a HbA1c between 5.7 and 6.4 is consistent with prediabetes. For Individual #62, the results should be verified and if prediabetes is confirmed, interventions should be implemented. The PCP made no comment on this important ADA

guideline. Unfortunately, the AMA stated that the A1c of 5.8 was normal. This resulted in an incorrect risk rating for diabetes for Individual #62.

- Individual #188's prolactin level was reported as asymptomatic. This individual received multiple medications that impact potassium balance (i.e., ACE inhibitor, diuretic, and albuterol). There was no comprehensive metabolic panel (CMP) submitted in the lab reports. The QDRR noted the last CMP was completed in December 2016. The Clinical Pharmacist made no recommendation for monitoring this issue.

- For a few individuals, the Clinical Pharmacist provided no comments on the effectiveness of treatment for osteoporosis and/or the need for a repeat DEXA scan.

With regard to the use of second generation antipsychotics, Individual #221 was prescribed Latuda. The Clinical Pharmacist did not comment on it. For Individual #59, who was prescribed Zyprexa, the Clinical Pharmacist listed abnormal cholesterol levels, but made no further comments. Under the discussion of metabolic syndrome, the Clinical Pharmacist noted the following: "Metabolic Syndrome: Triglycerides (greater or equal to 150mg/dl, or treated), HDL (males less than or equal to 40mg/dl, females less or equal to 50mg/dl, or treated)." These are the criteria, but the Clinical Pharmacist did not specify how the individual met the criteria. The values should have been stated or there should have been notation of treatment. Additionally, under the lab section, the Clinical Pharmacist simply noted lipids 11/18/2016 – WNL (within normal limits). For individuals who are prescribed statin therapy guided by ASCVD risk scores, the PCP might expect to see lipids decrease by a certain percentage. Therefore, stating that lipids are WNL is not helpful. Generally, simply noting that a lab is WNL might not be helpful. For example, stating that a HbA1c is WNL does not indicate if the individual has achieved adequate control. A1c targets are individualized based on clinical circumstances.

c. For the individuals reviewed, it was good to see that prescribers were generally were reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations. The exception was for Individual #221, for whom the prescriber(s) did not indicate agreement or disagreement with recommendations related to obtaining an eye exam and a DEXA scan, although it appeared these tests were subsequently ordered.

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 monitoring.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
c.	Monthly progress reports include specific data reflective of the	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1

	measurable goal(s)/objective(s);	0/8									
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1

Comments: a. and b. Individual #188 was at low risk, but was part of the core group, so a full review was conducted. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings. Individual #46's IDT had rated him at low risk, but according to his dental exam, he had progressed from Class 1 to Class 2 periodontal disease. None of these individuals had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.

Summary: These are new indicators, which the Monitoring Team will continue to review.

#	Indicator	Overall Score	Individuals: 170	120	235	46	584	59	62	188	221
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.	0% 0/3	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/1	0/1
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	33% 2/6	1/1	0/1	N/A	0/1	0/1	0/1	1/1	N/A	N/A
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: a. Although at the time of the review, individuals reviewed did not have untreated dental caries, the following example was concerning:

- According to the 11/23/16 dental summary, Individual #59's last prophylactic care occurred on 7/28/14. On 8/16/16, she had refused to come to the dental clinic, and the IDT was informed of the refusal with a request for assistance. On 12/22/16, the PCP spoke with the Dental Director about pain and a possible connection to self-injurious behavior. On 12/23/16, the dentist saw Individual #59, and wrote that a tooth was extracted because it was non-restorable. However, the nursing and PCP

notes indicated the individual had an abscess with a fistula to the right upper molar, and, therefore, the tooth was extracted. On 1/22/17, under TIVA, the individual had seven restorations due to decay.

b. It is important to point out that these findings indicate that all individuals reviewed had periodontal disease. For many individuals reviewed (e.g., Individual #120, Individual #235, Individual #46, Individual #584, Individual #59, Individual #188, and Individual #221), because up-to-date periodontal charting or x-rays were not completed, evidence was not available to determine the status of their periodontal condition.

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 Dental Department should focus on providing timely prophylactic care as well as fluoride treatment, and developing and implementing plans to address individuals' periodontal disease with the assistance of residential staff. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	75% 6/8	1/1	1/1	0/1	1/1	1/1	N/A	0/1	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.	67% 6/9	1/1	1/1	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.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	80% 4/5	N/A	0/1	N/A	N/A	N/A	1/1	1/1	1/1	1/1
g.	If the individual requires an extraction, it is done only when	100%	1/1	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A

	restorative options are exhausted.	3/3									

Comments: a. through f. A number of individuals reviewed had not had needed dental treatment.

d. For Individual #59 and Individual #221, documentation submitted was unclear with regard to whether they had fluoride treatment, chlorhexidine treatment, or both.

f. Based on documentation submitted for Individual #120, on 11/9/16, the dentist documented that a resin composite had fallen out of tooth #11. However, the dentist did not document follow-up to replace the restoration.

Outcome 7 – Individuals receive timely, complete emergency dental care.

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 170	120	235	46	584	59	62	188	221
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 3/3	1/1	N/A	N/A	N/A	N/A	1/1	1/1	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	67% 2/3	1/1					1/1	0/1		
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 3/3	1/1					1/1	1/1		

Comments: a. through c. For Individual #59, on 12/22/16, the PCP spoke with the Dental Director about pain and a possible connection to self-injurious behavior. On 12/23/16, the dentist saw Individual #59, and wrote that a tooth was extracted because it was non-restorable. However, the nursing and PCP notes indicated the individual had an abscess with a fistula to the right upper molar, and, therefore, the tooth was extracted.

For Individual #62, on 3/3/17, a provider documented that: "RN CM [Case Manager] and nursing staff and DSP are all reporting that patient has been banging her head and hitting her head and crying. The current episode has been going on for about a week or more. The report today is that Tramadol is not effective in relieving her pain. Everybody seems to be very concerned today and insisting that 'something is off.' The patient is also reported to be vomiting at night." The assessment was headaches and the plan was to obtain a computed tomography (CT) scan, and decide later on Ear, Nose, and Throat (ENT) and Neurology consults.

On 3/8/17, Individual #62's PCP documented the symptoms continued. The plan was to restart a decongestant and obtain CT scan the next day. The PCP did not conduct a physical assessment.

On 3/12/17, the PCP documented an on-call note stating: "staff reported possible pain, source not clear." The CT was noted to be normal, as well as the complete blood count (CBC). A dental consult was requested. On 3/13/17, dental staff noted that the individual was "observed" in clinic by the Registered Dental Hygienist (RDH), and the only finding was poor oral hygiene. Individual #62 was to return to the clinic in one week to see the dentist. On 3/14/17, the PCP noted that the CT was done and the dentist had established no dental caries. However, the dentist did not document this finding. The RDH observed the individual in clinic. The plan was to obtain an

ENT consult.

On 3/21/17, the dentist documented that the individual was seen for "c/o [complaints of] self-abuse/hitting on head." There was no documentation of any type of dental exam or attempt to examine the individual. The plan was to schedule TIVA for 3/22/17. On 3/22/17, the dentist treated multiple caries under TIVA.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/2	N/A	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/2			0/1	0/1					
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/2			0/1	0/1					
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/2			0/1	0/1					
Comments: a. through d. For the two individuals for whom this was applicable, the Center did not submit documentation related to suction tooth brushing.											

Outcome 9 – Individuals who need them have dentures.											
Summary: Improvements were needed with regard to the dentist's assessment of the need for dentures for individuals with missing teeth.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	50% 4/8	1/1	1/1	0/1	1/1	0/1	0/1	1/1	0/1	N/A
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. For the individuals reviewed with missing teeth, the Dental Department often did not provide recommendations regarding dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									
Comments: a. through f. Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected. The Monitoring Team discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist in the documentation provided. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should work with State Office to correct this issue.										

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	17% 3/18	0/2	1/2	1/2	0/2	0/2	1/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #170 – weight, and falls; Individual #120 – circulatory, and UTIs; Individual #235 – constipation/bowel obstruction, and infections; Individual #46 – skin integrity, and hypothermia; Individual #584 – aspiration, and seizures; Individual #59 – choking, and dental; Individual #62 – GI problems, and skin integrity; Individual #188 – cardiac disease, and falls; and Individual #221 – fractures, and skin integrity).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #120 – UTIs, Individual #235 – constipation/bowel obstruction, and Individual #59 – choking.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.	
Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These	Individuals:

indicators will remain in active oversight.											
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
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% 0/15	0/2	0/1	0/2	0/2	0/2	0/1	0/2	0/1	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: As noted above, the Monitoring Team reviewed a total of 18 specific risk areas for nine individuals, and as available, the IHCPs to address them. a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.										

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
Summary: For the two previous reviews, as well as this review, the Center did well with the indicator related to nurses administering medications according to the nine rights. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators 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.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R									
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right	100% 7/7	N/R	1/1	1/1	1/1	1/1	N/R	1/1	1/1	1/1

	time, right reason, right medium/texture, right form, and right documentation).										
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/A									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	100% 2/2	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 6/6		1/1	1/1	1/1	1/1		N/A	1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	67% 4/6		1/1	0/1	1/1	0/1		1/1	1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									

m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R										

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of seven individuals, including Individual #120, Individual #235, Individual #46, Individual #584, Individual #62, Individual #188, and Individual #221.

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

d. It was very positive to see that for the two applicable individuals, nursing staff completed lung sounds before and after medication administration in accordance with the related action steps in their IHCPs.

f. It was also positive that nursing staff implemented individuals' PNMPs during medication administration.

g. With regard to infection control practices, problems included:

- The nurse administering Individual #235's medications did not consistently use proper glove technique.
- For Individual #584, the medication nurse did not consistently use aseptic technique with the gastrostomy tube port.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Although improvement was still needed, IDTs often referred individuals to the PNMT when they met referral criteria. 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	170	120	235	46	584	59	62	188	221
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	0/2	0/2	N/A	0/1	0/1	0/1	0/2	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/11	0/1	0/2	0/2		0/1	0/1	0/1	0/2	0/1
	iii. Integrated ISP progress reports include specific data	0%	0/1	0/2	0/2		0/1	0/1	0/1	0/2	0/1

	reflective of the measurable goal/objective;	0/11									
	iv. Individual has made progress on his/her goal/objective; and	0% 0/11	0/1	0/2	0/2		0/1	0/1	0/1	0/2	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/11	0/1	0/2	0/2		0/1	0/1	0/1	0/2	0/1
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	N/A	N/A	2/2	0/1	0/1	1/1	N/A	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1			0/2	0/1	0/1	0/1		0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/7	0/1			0/2	0/1	0/1	0/1		0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/7	0/1			0/2	0/1	0/1	0/1		0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/7	0/1			0/2	0/1	0/1	0/1		0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1			0/2	0/1	0/1	0/1		0/1

Comments: The Monitoring Team reviewed 11 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: weight for Individual #170; choking, and fractures for Individual #120; skin integrity, and fractures for Individual #235; circulatory for Individual #584; choking for Individual #59; skin integrity for Individual #62; choking, and falls for Individual #188; and weight for Individual #221.

a.i. and a.ii. None of the IHCPs reviewed included clinically relevant, achievable, and/or measurable goals/objectives.

b.i. The Monitoring Team reviewed seven areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included: falls for Individual #170; skin integrity, and aspiration for Individual #46; aspiration for Individual #584; weight for Individual #59; GI problems for Individual #62; and fractures for Individual #221.

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

- On 8/4/16, a modified barium swallow study (MBSS) recommended that Individual #584 have an enteral tube placed. No evidence was presented to show that her IDT referred her to the PNMT at that time.
- In September 2016, Individual #59 weighed 109.8 pounds with weight loss to 90.1 on 10/12/16, and general continued weight

loss through 1/10/17, when she weighed 80.8 pounds. On 1/18/17, Individual #59's IDT referred her to the PNMT due to weight loss. On 1/19/17, the PNMT completed a review and determined that a comprehensive assessment was indicated. However, her IDT should have referred her or the PNMT should have made a self-referral much sooner.

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

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	21% 3/14	0/2	1/2	1/1	0/2	0/1	0/1	1/2	0/1	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% 0/3	N/A	N/A	N/A	0/2	0/1	0/1	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, documentation often was not present to show implementation of even those that were included.

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

- Individual #170 was at high risk for weight issues, but did not have an IHCP to address this risk area.
- On a positive note, Individual #170's IDT referred him to the PNMT to address falls. As discussed elsewhere in this report, The IDT had determined that changes in his Tegretol doses were the root cause of his falls. With little evidence to support this finding, the PNMT essentially concurred, and concluded the IHCP was appropriate. Medication changes occurred in February 2017. Although Individual #170's falls diminished somewhat, they continued at a significant rate through March 2017. At the time of the Monitoring Team's onsite review, Individual #170 continued to experience falls, and his IDT and/or the PNMT had not explored all of the different potential causes of these falls, including collecting and analyzing data related to medical,

behavioral, environmental, and lifestyle factors that might be contributing to his falls.

- In August 2016, the PT initiated direct therapy with Individual #120 after the removal of a cervical collar, following a fracture of her cervical spine. In April 2017, the PT discharged Individual #120 from direct therapy due to limited progress. The PT recommended that a medical consultant see her to address muscle relaxation, and then the PT would carry out recommendations from the consulting MD. However, no evidence was submitted to show that this occurred.
- Individual #188's IDT discussed falls generally in the context of his behaviors, but the causes of many of the falls were listed as trips or loss of balance. Therefore, it was not clear that the IDT had identified the underlying etiology(ies) of his many falls or developed a sufficient action/support plan to minimize his risk.
- For Individual #221, the PNMT identified actions that should have been addressed related to Depo-Provera injections, consideration of an alternate method of birth control, and the need for a DEXA scan. However, the IDT, did not address these recommendations through an ISPA meeting or a revised IHCP.

c. The following provide examples of problems noted:

- IDT/PNMT follow-up documentation was not found for Individual #46 in relation to aspiration pneumonia and/or a pressure wound.
- The Center's response to the Tier I document request indicated that on 12/22/16, the PNMT discharged Individual #584. No ISPA documentation was submitted to show the PNMT met with the IDT to discuss the discharge, but it appeared at this time, Individual #584 was re-referred to the PNMT. On 3/31/17, she was discharged, but still there was no evidence of an ISPA meeting to discuss the discharge.
- For Individual #59, an IPN, dated 5/11/17, stated the PNMT would discharge her. On 5/18/17, an ISPA meeting apparently was held, but according to documentation submitted, members of the PNMT were not present. In its comments on the draft report, the State indicated that the Speech Language Pathologist in attendance at the meeting was a core member of the PNMT. However, she was not listed in this capacity on the list of people in attendance at the meeting, but rather appeared to be a member of Individual #59's IDT. This ISPA meeting did not result in the identification of supports and interventions the PNMT recommended be integrated into the IHCP. Essentially, it was limited to discussion about the fact that Individual #59 had regained some weight and no longer needed PNMT services. The supports needed to maintain her weight were not listed. Re-referral criteria was identified as a three-pound weight loss for two consecutive months. The red dot status (i.e., need for specifically trained staff to implement her dining plan) could not be determined during this meeting, but the IDT members present indicated they would do this in the future when the whole IDT could be present. This question should have been addressed at the time of PNMT discharge.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and	

address them.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	56% 42/75	
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.	36% 5/14	
Comments: a. The Monitoring Team conducted 75 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during nine out of 26 observations (35%). Staff followed individuals' dining plans during 32 out of 44 mealtime observations (73%). Staff completed one out of five transfers (20%) correctly.			

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A			N/A						
Comments: a. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For the individuals reviewed, IDTs overall 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	170	120	235	46	584	59	62	188	221
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/9	0/1	0/1	0/2	0/1	0/1	N/A	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including	0%	0/1	0/1	0/2	0/1	0/1		0/1	0/1	0/1

	timeframes for completion.	0/9									
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/9	0/1	0/1	0/2	0/1	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	0/2	0/1	0/1		0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/2	0/1	0/1		0/1	0/1	0/1

Comments: a. and b. Individual #59 had functional motor skills, and so a goal was not indicated.

Although Individual #120's goals/objectives for direct therapy (i.e., pivot transfer, standing balance, and cervical lateral flexion) were clinically relevant and measurable, they were not included in her ISP or incorporated through an ISPA. Similarly, Individual #235 had direct OT and PT goals that were largely measurable, and most were clinically relevant, but none were included in her ISP or incorporated through an ISPA. Based on a limited PT assessment, Individual #46 had direct PT goals that were not incorporated into his ISP or discussed during an ISPA.

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

Individual #59 was part of the outcome group, so the Monitoring Team completed a limited review. The Monitoring Team conducted full reviews for the remaining eight individuals.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/3	N/A	N/A	0/1	0/1	N/A	N/R	N/A	N/A	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 meeting, then an ISPA meeting is held to discuss and approve the change.	25% 1/4	N/A	0/1	1/1	0/1	N/A		N/A	N/A	0/1

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

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.	
Summary: Given the importance of the proper fit of adaptive equipment to the	

health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** Due to the number of individuals reviewed for this indicator, scores continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	109	10	45	42	599	235	112	88	12
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	50% 11/22	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
		Individuals:									
#	Indicator		441	117	518	422	334	236	262	540	225
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		551	321	211	18					
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	0/1					
Comments: c. The Monitoring Team conducted observations of 22 pieces of adaptive equipment. Based on observations of Individual #109, Individual #10, Individual #45, Individual #42, Individual #599, Individual #235, Individual #112, Individual #88, Individual #441, Individual #422, and Individual #18 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.											

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. At the last review, one indicator was moved to the category of requiring less oversight. At this review, no other indicators will be moved to this category.

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

Given that almost all ISP personal goals did not meet criterion with ISP indicators 1-3, the indicators of this outcome also did not meet criteria. Two of the three goals that met criteria with these indicators, however, were progressing, which was good to see. Staff were generally knowledgeable about individuals' risks and ISPs. An ongoing need was to ensure that the goals and action plans were implemented.

SAPs did not have reliable data so that progress could be determined. For those SAPs for which the facility reported no progress, no actions were taken to modify the SAP. Some very typical types of SAP components were missing. Most SAPs that were observed by the Monitoring Team were not done correctly. A new SAP management system was being put in place at the time of this onsite review.

Improving engagement by offering new activities was a focus of the Lufkin SSLC over the past few months, including having it as one of the facility's five CAPs in response to the last monitoring report. Examples are provided below in the report. Individuals had opportunities for community outings, however, there should be some goal frequencies for outings as well as for SAP training in the community.

Overall, IDTs did not have a way to measure communication outcomes for the individuals reviewed. Although some improvement was noted since the last review with regard to AAC devices being present and readily accessible, more work in this regard is still needed. In addition, it was concerning that often when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.

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.	Individuals:

Two of the three goals that met criteria with these indicators were progressing, which was good to see. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	120	170	19	237	59	188			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	2/6	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	1/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
4-7. 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 with indicators 1 and 2, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available. For the three goals that did have data, the QIDP monthly review indicated that Individual #170 was making progress towards two of his goals. Individual #188 was not making progress towards his greater independence goal.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: It was good to see that staff were generally knowledgeable about individuals' risks and ISPs. An ongoing need was to ensure that the goals and action plans were implemented. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	120	170	19	237	59	188			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	87% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. Overall direct support staff were generally able to describe individual's health and behavioral risks. Staff were knowledgeable regarding individuals' ISPs based on observations and interviews. As noted above, ISPs rarely included detailed instructions to guide staff when implementing the ISP.

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

Skill Acquisition and Engagement

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

Summary: SAPs did not have reliable data so that progress could be determined. For those SAPs for which the facility reported no progress, no actions were taken to modify the SAP. These four indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
6	The individual is progressing on his/her SAPS	0% 0/23	0/2	0/3	0/2	0/2	0/3	0/3	0/3	0/3	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/11	0/1	N/A	N/A	0/2	N/A	0/3	0/1	0/3	0/1
9	Decisions to continue, discontinue, or modify SAPs were data based.	27% 4/15	1/2	N/A	N/A	0/2	N/A	0/3	2/3	0/3	1/2

Comments:

6. None of the SAPs were rated as progressing. Some SAPs (e.g., Individual #170's waiting for change SAP) were not making progress. Some SAPs did not have sufficient data to determine progress (e.g., Individual #401's identify coins SAP), however, were scored as not making progress because the data were not demonstrated to be reliable (see indicator 5). Finally, some SAP data did indicate progress (e.g., Individual #3's track his money SAP), but were scored as not making progress because they did not have reliable data.

8-9. In none of the 11 SAPs that were judged to not be progressing (e.g., Individual #237's state normal blood pressure range SAP) were there actions to address the lack of progress. Overall, there were data based decisions to continue, discontinue, or modify SAPs in 27% of the SAPs.

Lufkin SSLC should ensure that SAP progress is closely monitored and that data based decisions to continue, discontinue, or modify SAPs are consistently applied.

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

Summary: Performance remained low. Some very typical types of SAP components were missing. A new SAP management system was being put in place at the time of this onsite review. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
13	The individual's SAPs are complete.	9% 2/23	0/2	0/3	1/2	0/2	1/3	0/3	0/3	0/3	0/2

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Individual #401's state her address SAP, and Individual #517's brush his hair SAP were found to contain all of those elements.

Lufkin SSLC recently began to develop a new SAP training procedure. Seven of the new format SAPs were reviewed. It was encouraging that the two complete SAPs were in the new SAP format.

A common missing component among the old format SAPs was the lack of specific instructions to teach the skill. The majority of the SAP training sheets indicated a training methodology (e.g., forward chaining) that should be used for training the SAP. None of the SAP training sheets, however, contained explanations of the training methodology. Additionally, none of the old format SAPs contained a documentation methodology.

Some common missing components for both old and new format SAPs were the absence of instructions of how to address steps that follow or precede the identified training step (e.g., Individual #401's file her nails SAP), and the generalization plan not being complete (e.g., Individual #120's complete her vocational activity SAP).

Outcome 5- SAPs are implemented with integrity.

Summary: Most 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.

Individuals:

#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
14	SAPs are implemented as written.	20% 1/5	N/A	1/2	N/A	N/A	0/1	N/A	0/2	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.	0% 0/23	0/2	0/3	0/2	0/2	0/3	0/3	0/3	0/3	0/2

Comments:
14. The Monitoring Team observed the implementation of five SAPs. Individual #120's complete her vocational activity SAP was judged to be implemented and documented as written. Individual #120's make coffee, Individual #19's identify shapes and identify letters, and Individual #401's identify coins SAPs were not judged to be implemented as written. In order to maximize the learning of

new skills, it is critical that all staff consistently implement SAPs in the same way. Ensuring that SAPs are consistently implemented as written should be a priority for Lufkin SSLC. Implementation of SAPs for the other individuals' SAPs were not observed due to individual refusals or unavailability. In addition, the new SAP coordinator stated that the same low level of correct implementation would be evident in these other SAPs. Correct implementation is a priority for the facility and the new SAP coordinator.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. None of the SAPs had integrity measures. Lufkin SSLC had, however, developed a tool to measure SAP integrity, and established a schedule of SAP integrity that would ensure that each SAP was observed/assessed at least once every six months.

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

Summary: It was good to see that SAPs were being reviewed and being graphed. Once the quality of the content and implementation improve, conducting monthly reviews can be meaningful for the individual and the IDT. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
16	There is evidence that SAPs are reviewed monthly.	60% 12/20	2/2	N/A	0/2	1/2	2/3	0/3	3/3	2/3	2/2
19	SAP outcomes are graphed.	100% 20/20	2/2	N/A	2/2	2/2	3/3	3/3	3/3	3/3	2/2

Comments:
16. Eight SAPs (e.g., Individual #401's file her nails SAP) were not included in the SAP monthly reviews. Individual #120's SAPs were not included in this indicator's score because they were developed after the monthly review.

19. SAP data were consistently graphed. Individual #120's SAPs were not included in this indicator's score because they were not implemented at the time of the monthly SAP review.

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

Summary: All four indicators showed improvement since the last review (indicator was already at 100% last time, too). This was good to see and perhaps was, at least in part, a result of the many campus-wide activities and focus on engagement and activities. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	0/1	1/1	0/1	1/1	0/1	0/1	1/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	67% 6/9	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:

18. The Monitoring Team directly observed nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found three (Individual #120, Individual #237, Individual #19) of the nine individuals to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. Lufkin SSLC tracked engagement in all residential and treatment sites. Their established engagement goal was individualized to each residence and day program site. The facility's engagement data indicated that 67% of the residential sites of the individuals (i.e., Individual #3, Individual #170, Individual #19, Individual #415, Individual #401, Individual #517) achieved their goal level of engagement.

Improving engagement by offering new activities was a focus of the Lufkin SSLC over the past few months, including having it as one of the facility's five CAPs in response to the last monitoring report. Some examples are:

- The new organizational model at the 550 day program building.
- The brand new art class with the teacher from the community.
- Small group activities occurring in the homes in the evening.
- Employment opportunities in the community.
- Summer camp for the school children. Various interesting activities were planned each day for them, such as the water slide at day camp on campus, or going into town to the movies. That being said, not all of the children participated and alternate activities were not planned.

In addition, the engagement/activity department created a document "Active Treatment and Engagement" that included a listing of 74 different activities that were available to individuals. This was good to see and demonstrated some of the creative thinking going on at Lufkin SSLC. The Monitoring Team suggests that the department consider measuring the number of individuals who participate in each of these 74 activities each month and, perhaps, how often and for how long.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Individuals had opportunities for community outings, which was good to see, however, there should be some goal frequencies for outings as well as for SAP training in the community. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	279	120	517	237	401	415	19	170	3

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

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary:			Individuals:								
#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments:											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the	N/A									

	measurable goal(s)/objective(s);										
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: a. through e. Based on the documentation the Center provided, none of the individuals reviewed had refused dental services.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, IDTs did not have a way to measure communication outcomes for the individuals reviewed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	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.	Integrated ISP 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 communication goal(s)/objective(s).	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 or criteria for achievement have been met, 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 #170 and Individual #584 had functional communication skills. Although Individual #120 used verbal communication, it was unclear whether she needed communication supports due to the fact that the two-year old screening was insufficient to allow the IDT to make this determination.

None of the individuals reviewed had goals/objectives that were clinically relevant, as well as measurable.

c. through e. As noted above, Individual #170 and Individual #584 had functional communication skills. Individual #584 was part of the outcome group, so further review was not conducted for her related to communication. Individual #170 was part of the core group, so a full review was conducted for him. For the remaining seven individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of sufficient justification in communication assessments to support the decision that the individuals did not need formal communication supports.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	170	120	235	46	584	59	62	188	221
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/1	N/A	N/A	N/A	N/A	N/R	0/1	N/A	N/A	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/1	N/A	N/A	N/A	N/A		N/A	N/A	N/A	0/1
Comments: a. Many individuals that should have had communication supports did not. For Individual #59, no evidence was found that the SLP addressed the action step to review the use of the bathroom switch. The SLP was not in attendance at the ISP meeting. b. Individual #221's IDT discontinued her communication board. However, given that it had been repaired or replaced 15 or more times, and the SLP had not conducted a reassessment and/or recommended an alternative, it was unclear what basis the IDT had to discontinue this support and/or not replace it with another option.											

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: The Center should continue its efforts to ensure individuals have their AAC devices with them, and should focus on ensuring that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring. [**Note:** Due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]			Individuals:								
#	Indicator	Overall Score	68	285	458	117	402	471	85	352	422
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	67% 10/15	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	33% 5/15	0/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1
			Individuals:								
#	Indicator		506	101	17	192	221	59			
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	1/1	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.		0/1	1/1	0/1	0/1	0/1	0/1			
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	57% 4/7									
Comments: a. and b. Although some improvement was noted since the last review with regard to AAC devices being present and readily accessible, more work in this regard is still needed. In addition, it was concerning that often 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.

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

The transition department's Admissions and Placement Coordinator was very experienced and knowledgeable about the transition process and the community provider system. The other members of the transition department staff were somewhat new, but now had about nine months to a year of experience under their belts and were very open to feedback and suggestions. Of positive note, they already had identified the same issues regarding a variety of areas, as did the Monitoring Team, especially regarding transition assessments.

CLDPs contained many supports, but improvement is needed in the CLDP content (i.e., the quality and comprehensiveness of the list of supports). For instance, the lists of supports were not comprehensive; many needs of the individual that were evident in their ISPs, IRRFs, IHCPs, PBSPs, ISPAs, and transition assessments did not make it into the list of supports. Even some aspects of supports and services that were clearly playing a role in the individual's success at the Center, were left off the list of CLDP supports. The CLDP should document the flow from assessment and recommendations to deliberations/discussion to final recommendations. Even so, there were some good examples of supports and some good examples of supports written in measurable terms. The Center staff should build on these as well as look at the details provided in the comments below.

The new post move monitor conducted post move monitoring in a thorough manner, though some aspects needed improvement, such as directly interviewing the community provider direct support staff, directly observing the individual's medications, and looking for all three types of evidence of support provision (interview, observation, documentation).

One individual had serious negative events that resulted in a return to live at Lufkin SSLC. 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.

Once referred, individuals' transitions received timely and frequent attention.

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: Improvement is needed for the CLDP content (i.e., the quality and comprehensiveness of the list of supports) to meet the various criteria required by these two indicators and their sub-indicators. For instance, the lists of supports were not comprehensive; many needs of the individual that were evident in their ISPs, IRRFs, IHCPs, PBSPs, ISPAs, and transition assessments did not make it into the list of supports. Even some aspects of supports and services that were clearly playing a role in the individual's success at the Center, were left off the list of CLDP supports. The CLDP should document the flow from assessment and recommendations to deliberations/discussion to final recommendations. Even so, there were some good examples of supports and some good examples of supports written in measurable terms. The Center staff should build on these as well as look at the details provided in the comments for these indicators below. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	228	126							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments: Nine individuals transitioned from the facility to the community since the last monitoring review. Two were included in this review (Individual #228 and Individual #126). Both individuals transitioned to a group home that was part of the State's Home and Community-based Services (HCS) program. The Monitoring Team reviewed these two transitions and discussed them in detail with the Lufkin SSLC Admissions and Placement staff while onsite.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how needs and preferences must be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. For these two CLDPs, many, not all, of the supports provided the Post Move Monitor (PMM) with measurable criteria or indicators that could be used to ensure supports were being provided as needed. Examples of supports that met criterion and those that did not meet criterion are provided below.

- The IDT developed six pre-move supports for Individual #228 and 17 for Individual #126. Neither CLDP included pre-move training supports indicating what provider staff knowledge or competence was required to provide the needed supports, but should have. The only pre-move supports related to training for these CLDPs required that the provider identify a responsible person to ensure that all current and future staff members had been inserviced. Pre-move training supports should address both the content of training provider staff would need as well as describe how staff competence to provide the supports would

be assessed. The Center must be able to verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety.

- The respective IDTs developed 28 post-move supports for Individual #228 and 48 post-move supports for Individual #126. Both CLDPs included many measurable supports, especially related to arranging for medical appointments and consultations, laboratory testing requirements, and provision of equipment and materials by the Center for use at the community home. Examples of post-move supports that did not meet criterion for measurability included:
    - Both CLDPs included supports related to the individuals' Positive Behavior Support Plans (PBSP), but neither met criterion for measurability. For Individual #228, the support called only for monitoring and documenting target behaviors, but did not indicate the target behaviors, staff actions to reduce the likelihood of behavior problems and responses if a behavior problem occurred, or the expectations for documentation. Individual #126's CLDP included a support to provide inservice for new staff or staff that needed new training. It was positive to see that the support provided specific details about the content of the training, but it did not describe how staff knowledge or competence would be determined. The evidence required did not include any staff interview or other verification of competence to provide these supports.
    - For Individual #228, a support called for staff to monitor the signs and symptoms of his medications, but did not specify what any of those signs or symptoms might be.
    - For Individual #126, a support called for the provider to re-inservice their staff on the day of transition on a variety of support needs, but did not provide any specific competencies or require evidence of staff knowledge.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place for this indicator to be scored as meeting criterion. These two CLDPs did not comprehensively address support needs and did not meet criterion. Comments on each of the seven aspects are provided below.

a. Past history, and recent and current behavioral and psychiatric problems: Supports did not sufficiently reflect past history, and recent and current behavioral and psychiatric problems in a thorough manner. Examples included:

- The CLDP did not fully address the need for staff knowledge regarding Individual #228's behavioral and psychiatric history, such as his history of assault and other aggressive behaviors, repeated psychiatric hospitalizations, and frequent flight behavior. It also did not accurately convey the seriousness of current behavioral concerns. For example, the CLDP indicated no restraint had been required since March 2016, but restraint documentation reviewed by the Monitoring Team included a restraint that occurred on 3/30/17, less than three weeks before the CLDP meeting was held. The IDT did not develop a specific pre- or post-move support for staff training or knowledge of this history or how to address these historical and current concerns. A post-move support called for staff to continue to monitor and document the target behaviors in his positive behavior support plan (PBSP), but did not provide any specific description of the behaviors staff needed to be familiar with. As described further below, the CLDP also did not include a support describing strategies for positive reinforcement and other preventative strategies, or a supervision support to ensure staff had knowledge of his needs in this area.
- Individual #228 also had several restrictions, including pocket checks to ensure he did not have possession of a working cigarette lighter, and limited opportunity to smoke. The smoking schedule was included in the supports, but the lighter restriction and pocket checks were not.

- For Individual #126, the CLDP included an extensive support describing the methodology of the PBSP, which was good to see, but the support did not require any verifiable evidence of staff knowledge or competence. To achieve compliance, the IDT should specify the how the provider should be able to demonstrate the provision of the support as well the evidence the PMM should review to confirm the support was in place.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: Overall, the Center evidenced some progress in developing supports that addressed safety, medical, healthcare, therapeutic, risk, and supervision needs. As noted in indicator 1, the respective IDTs developed many supports to ensure medical/healthcare treatments and consultations were provided as needed and in a timely manner. Some supports also clearly indicated signs and symptoms that needed to be reported to the nurse and the timeframes in which those reports should be made, while some did not. Overall, however, the respective IDTs did not develop comprehensive supports for some significant needs in these areas. Examples included:

- The CLDPs did not include pre-move training supports that specified direct support staff needed to be trained to a specific level of competency for medical, healthcare, therapeutic, and risk needs. Post-move supports often identified actions staff were to take in these areas, but no pre-move verification of training, knowledge, or competency was required. It is incumbent on the IDTs to verify that staff have knowledge and display competence about these important needs on the first day of transition.
- The CLDP did not include comprehensive supports regarding Individual #228's required level of supervision while in the community. The CLDP narrative advised an increased level of supervision during the initial transition phase and that staff should always be aware of Individual #228's whereabouts at the home, day hab, and while out in the community. It continued that Individual #228 would be fine to sit in the back or front yard smoking without staff supervision or staying inside the home if staff were to step outside to smoke and that the provider could look at adjusting his level of supervision as appropriate after Individual #228 became familiar with his new environment. The narrative noted Individual #228 had a history of flight, running and hiding from staff, and physical aggression toward staff and peers, but it did not make clear the current frequency of these behaviors or the extent to which supervision was required at the time of the CLDP. He had been making progress but still required enhanced supervision while out of his room during much of the day and staff were instructed during those times to stay close enough to prevent flight or aggression. It was concerning the IDT did not develop a supervision support or require evidence that provider staff were knowledgeable of these needs.
- In addition, Individual #228 had a restriction for visitation with his biological father only under supervision and only at the provider's location. The CLDP noted this in the narrative, but the IDT did not develop a related support.
- Individual #228 had an allergy to the stings of flying insects and required an Epi-pen to be available whenever he was outdoors. He was not allowed to carry the pen on his person. Instead, a direct support staff trained to administer the injection was to have possession of the pen, administer the injection and notify the nurse. The CLDP narrative stated he had an Epi-pen for a bee sting allergy and that it must be kept in the home and day program, as well as taken on community outings, but did not provide the more specific details. In any event, this need was not addressed in the CLDP supports.
- Individual #228 also had a significant history of refusing medical and dental appointments and procedures. The CLDP narrative included some effective strategies for addressing this issue, but the IDT did not develop a related support for staff to carry out.

- The CLDP for Individual #126 did not have a clear support for level of supervision needed, stating that it was "routine."
- Overall, the IDT for Individual #126 addressed his medical and health care needs with extensive supports. Most habilitation therapy needs were also addressed, except for the need to monitor dorsal lumps on his right thumb that should be evaluated by an orthopedist if they worsened.
- Individual #126's supports for communication did not provide needed detail. His CLDP included a pre-move support for the Center to provide a communication poster and a post-move support calling for staff to encourage Individual #126 to use the poster if he became agitated. No support described his communication skills or how to use the communication poster to foster ongoing communication.

c. What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP for the section that lists the outcomes important to the individual. The IDTs should make an effort to individualize these outcomes, including referring to the preferences and personal goals identified in the ISP.

- For Individual #228, the outcomes included some that were clearly individualized, such as maintaining contact with his grandmother, having the opportunity to walk around, working and earning money, and making a new friend. The CLDP included a distinct support for maintaining his relationship with the grandmother, but did not have any supports for developing new friendships. The opportunity to walk around had been identified as being singularly important to Individual #228. For example, in addition to his expressed preference for this activity, his work refusals had dropped significantly once his job was structured to include walking around the campus. His Integrated Health Care Plan (IHCP) also indicated he should be encouraged to walk at least three times per week. The CLDP included this activity in a list of things he should have the opportunity to do, with no specific expectation of how often it should happen.
- Individual #126's CLDP also included a section describing his important outcomes, which were identified as continuing community outings that he enjoys, continuing to listen to music that he enjoys, to live in the community, and to continue aspiring to reach his goals. This did not reflect an individual approach. For example, per much of his transition documentation, the IDT repeatedly referred to his need for a routine schedule as an important outcome and could have included it in this section.

d. Need/desire for employment, and/or other meaningful day activities in integrated community settings:

- The CLDP included a pre-move support calling for Individual #228 to be provided with day habilitation services. This did not reflect his preferences and strengths. He had indicated prior to the move that he did not want to work, but was even more adamant that he did not want to attend a day habilitation program. Among the information found in his PSI and vocational assessment, such as an interest in working with cars or at an animal shelter, was that he was most proud of his ability to earn money. The IDT did acknowledge this in the CLDP narrative, but did not carry it over to a formal support. The narrative discussion and review of recommendations for the vocational assessment stated that Individual #228 had chosen to attend the provider's day habilitation program and that he would have the opportunity to earn money from cleaning the provider's corporate office one hour of each day, earning $10.00 an hour. It further stated he would have the opportunity to earn $50.00 weekly to pay for his cigarettes and other activities or outings of his choice. The CLDP did not include this in any support.
- Individual #126's CLDP included a support to attend a day habilitation program, which should be available Monday

through Friday for six hours per day. Another described skills he should work on in that setting. This was positive. It was concerning, though, that Individual #126 had the opportunity to work and earn money at the Center and no support was developed to achieve this in the community setting. It was doubly concerning because the IDT had deferred a community transition referral at his ISP just one month before the referral took place, in part because they wanted him to improve his completion of employment tasks, so he could earn more money.

- Neither CLDP focused on other meaningful day activities in integrated community settings.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success: The CLDP for Individual #228 did not include supports that specified strategies for positive reinforcement, incentives, and/or other motivating components to an individual's success. Individual #126's CLDP did have a support for his PBSP that included strategies for prevention, replacement behaviors, and scheduled reinforcement, which was positive. To meet criterion, his IDT should also have included a requirement for verifying that all staff who work with Individual #126 were knowledgeable and competent to implement the support.

f. Teaching, maintenance, participation, and acquisition of specific skills: Both CLDPs included some supports for skill acquisition and maintenance.

g. All recommendations from assessments are included, or if not, there is a rationale provided: The Center's process for reviewing CLDP assessments, documenting discussion and making final recommendations had not resulted in ensuring that all recommendations were addressed with needed supports. For the CLDPs reviewed, the Center had inserted the assessments as a whole, rather than summarizing significant findings and recommendations, a process that greatly increased the length of the document and hampered readability.

- For Individual #228, the IDT needed to undertake a more methodical approach to ensuring all the recommendations, including those found in assessment narratives, were discussed and finalized. The discussion was briefly documented and the final recommendations not clearly listed. The discussion did not make clear whether all recommendations had been considered. Consequently, some recommendations did not translate into supports.
- Also for Individual #228, the Monitoring Team noted the discussion section sometimes identified additional important information and recommendations, without clearly indicating if supports would be developed to address them. For example, the discussion section of Individual #228's nursing and dental assessments indicated he was often uncooperative with medical and dental appointments, but was much more likely to participate if you began discussing these with him weeks prior. Likewise, the Center nurse indicated he would be more willing to take his medications if staff began to discuss what he would need to take a couple hours prior to the scheduled time. These should have been translated to supports for staff knowledge.
- For Individual #126, the documentation of final recommendations was clearer, providing a list of final pre-and post-move supports derived from each assessment. This CLDP still did not clearly address all recommendations with either a support or a justification for not including it. For example, the social assessment recommended that Individual #126 be referred for a guardian or advocate. The CLDP narrative indicated the provider would implement a process for advocacy, but the IDT did not include a related support.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: The new post move monitor conducted post move monitoring in a thorough manner, though some aspects needed improvement in order to meet criteria with each of the indicators in this outcome. Further, improvements in the CLDP lists of supports will allow the PMM to be able to determine if supports are (or are not) being provided. The PMM's pleasant interaction style should also set the occasion for a good working relationship with community providers, SSLC IDT members, and individuals and their families. Her report detailed the monitoring activities observed by the Monitoring Team. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	228	126								
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 assessment is correct based on the evidence.	50% 1/2	0/1	1/1								
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	0% 0/1	N/A	0/1								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	N/A	1/1								
Comments: 3. Post-move monitoring had been completed for the 7-day PMM for Individual #228 and the 7, 45, and 90-day post move monitoring periods for Individual #126. The PMM completed Individual #228's visit within the required timeframes. For Individual #126, the PMM made both the 7- and 45-day visits on a timely basis, but the 90-day PMM visit was not made until 100 days had passed. The PMM completed each of these post-move monitoring visits in the proper format. The 180-day PMM visit for Individual #126 was held during												

the monitoring visit and observed by the Monitoring Team. For both individuals, the PMM provided comments regarding the provision of supports, and it was very helpful to read the overall narrative summaries for each PMM period at the beginning of the checklist. Still, some improvements were needed to this documentation process, as described below and throughout this Indicator:

- For some supports, the PMM did not provide comments that addressed the full scope of its requirements. For example:
  - For Individual #228, it was very important that he have the opportunity to walk around, as described above. A support to have the opportunity to enjoy leisure time was to include walking around, but the 7-day PMM checklist did not provide any information about whether he had engaged in that activity.
  - Individual #228 also had a support for monitoring of his blood pressure and heart rate on a daily basis. The 7-day PMM report indicated the PMM spoke with staff who said it will be checked each morning and documented on his medication administration record (MAR.) The PMM indicated no issues or concerns were noted, however, the evidence was supposed to include observations, interviews, documentation and or nursing notes. No documentation was reviewed.
- For Individual #126, some supports had comments that indicated observations, interviews, and documentation indicated supports were in place. Some of those indicated what documents were reviewed, while others did not. The PMM should consider adding this level of detail to all comments.

4. The PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports in some instances, but there were issues that compromised reliability and validity. In addition to the lack of complete comments as described above, it was not always possible to ascertain for either individual whether reliable and valid data were present, due in part to a lack of specificity and measurability of some supports, as described in indicator #1.

5. Based on information the Post Move Monitor collected, neither individual had not received all of his supports as needed. While many supports were provided, neither individual had received all supports as listed and/or described in the CLDP. For example:

- At the time of the 7-day PMM visit, Individual #228 had not been provided training for budgeting money or for how to write a check.
- For Individual #228, the PMM documented at the time of the 7-day that the home manager informed her that staff would notify the nurse if they noticed him having any of the symptoms listed. As described under indicator 1, the support did not actually list side effects or symptoms, instead it only listed the medications.
- Also for Individual #228, the PMM documented in the 7-day summary that it could not be determined how many hours a week he would work because it would be up to the need the day program had. While the support itself only required that he be provided with day habilitation services, there was a clear discussion in the CLDP that he would be able to work at least one hour a day and be able to earn $50 a week. This support was not being provided.
- For Individual #126, the provider had not implemented his skills training at the home or day program at the time of the 7-day PMM visit.
- At the time of the 45-day PMM visit, Individual #126 had not been seen by the dentist, as required.

6. Based on the supports defined in the CLDP, the scoring for Individual #126 appeared to be accurate. Some scoring for Individual #228 was not accurate based upon the available evidence. For example, as described above, Individual #228 was not receiving the full scope of the day program as indicated in the CLDP, and the PMM took note of this concern in the 7-day summary. The support for day

habilitation was still marked as present.

7-8. The Monitoring Team noted some good examples of follow-up to ensure needed follow-up took place. The PMM routinely documented actions taken to resolve areas of concern or unmet need on a timely basis in most cases. Transition staff indicated the IDT would meet if the PMM checklist identified issues that needed to be resolved, and that all reports were sent to the IDT for review. The Center may want to consider formalizing its expectations for documenting IDT review for all PMM Checklists. The PMM may not always identify or recognize issues that require follow-up, while an appropriate IDT member might be more likely to do so.

- The PMM did not accurately and consistently identify supports that were not being provided for Individual #228. Thus, follow-up needs were not identified as needed. For example, the concerns noted in indicators 5-6 should have prompted the PMM to identify needed follow-up.
- Overall, the PMM kept good documentation of follow-up to identified needs for Individual #126. It was positive to see the IDT had met twice to discuss follow-up needs after the 7-day and 90-day PMM visits. The Monitoring Team noted the IDT agreed to the discontinuation of the PBSP after the 90-day PMM visit, due to provider reports that Individual #126 had not exhibited any target behaviors, including included long-standing ritualistic behaviors. The basis for the IDT determination was not clear. In interview, transition staff indicated the smaller and quieter environment appeared to have allowed many of these behaviors to resolve naturally. This was a positive outcome of the transition, however, much of the PBSP included strategies for minimizing his anxiety, so it was not clear what part that may also have played in this improvement. In making its decision, the IDT needed to make a careful assessment, perhaps by having the Center behavioral staff observe Individual #126 in the new environment and/or requesting the provider's plan for integrating these strategies into ongoing staff training.

9. The Monitoring Team observed the conduct of post move monitoring by the PMM for the six-month review for Individual #126. Observation occurred at the individual's home. In addition to the PMM, the APC and two of the other transition department staff were present, but they did not participate in any post move monitoring activities. In addition to Individual #126, also present were his two housemates, his direct support staff, and the house manager. The PMM was diligent in monitoring for every support, one by one, collecting documentation and talking with the manager. This was all good to see. A few aspects of her post move monitoring, though, need attention. One is to conduct an interview with the direct support staff, not only with the house manager (who in this case only provided direct support in emergency situations). A second is to observe the actual medications and their storage. A third is to use all three "prongs" of post move monitoring, that is, observation, interview, and documentation to increase the PMM's confidence as to whether the support is (or is not) being provided.

10. The post move monitoring report for the visit observed by the Monitoring Team reflected what was observed by the Monitoring Team. There were lots of details in the report, too. The PMM described the evidence reviewed and status of each support in the narrative paragraph. The column "Evidence Reviewed" instead was copied from the CLDP. The State should consider revising this form to correct this column's title.

In this report, because many of the supports were not measurable, or did not define criteria, the PMM made a judgment as to whether the support was being provided as much as needed. This was relevant to supports, such as access and participation in preferred activities. Also, the report should include resolution of any of the areas of concern that are in the table at the end of the report.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: One individual had no negative events occur. The other had serious negative events that resulted in a return to live at Lufkin SSLC. 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	228	126								
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 #228 had experienced a PDCT event within the first 90 days after transition, having left the premises at the home and day habilitation program on multiple occasions. On one of these occasions, the provider had been unable to locate him for several hours and expressed concerns regarding his safety in the community. The provider had attempted to work with Individual #228's LAR to set up a contingency that allowed him to have visits with her after one week of complying with behavioral requirements. This had been unsuccessful, as he had sent staff a picture of himself with a knife to his neck while at his grandmother's home and, upon his return, threatened to kill staff and again left the home on several occasions. The provider also reported he was refusing to take his medications and was hiding them under his pillow. Individual #228 returned to live at the Lufkin SSLC on 6/9/17, after the IDT met with the LAR and she made that decision.

When discussing things that could have been done differently, the IDT indicated the provider could have considered other living arrangements within their program and that the LIDDA could have been more involved with identifying crisis intervention services or alternate providers in the community. While both of these may have been accurate, one of the important purposes of the PDCT process is to critically analyze the Center's actions during and after transition and use this information for process improvement in future transitions. Monitoring Team comments are below:

- The CLDP did not include any specific staff training regarding his extensive behavioral history, as described under indicator 2 above, or any verification of provider staff knowledge and/or competence for his PBSP. The PDCT documentation indicated that the provider reported attempting to allow Individual #228 time away from the home as long as he would check in, which he was not doing. This should have been a clear indicator to the IDT that provider staff did not have knowledge of his significant behavioral needs and caused the IDT to consider whether pre-move training and competency testing had been sufficient.
- Similarly, Individual #228's transition had been delayed due to criminal charges for assaulting his grandmother just months before his move to the community. This was not the first time he had assaulted her and in ISPA documentation she indicated that she was afraid of him. Sending him to her home in an agitated state also indicated a lack of understanding on the part of

the provider about his behavioral history. In response to this concern, transition staff noted that IDTs sometimes agreed with transition decisions they might not have otherwise agreed to, due to the opinions of an LAR, external organization involvement in the case, etc. It would be important to document these differences of opinion as well as any attempts made to resolve them.

- The PDCT documentation did not indicate how long he had not been receiving his medications as required, which could also have played a part in this decompensation. As described above under indicator 2, the Center was aware of his tendency to refuse medications and had discussed in the CLDP a strategy for beginning to let him know at least a couple of hours prior to the administration time to help him prepare. The IDT did not include this in the supports.
- The IDT should also have explored his work status and whether the lack of expected employment and the opportunity to earn money may have been a factor.

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 progress on some of the indicators, though as detailed below, improvements in quality are needed. The quality of transition assessments is an area of focus for the APC and her staff. Another area of focus is upon the training and competencies for community provider staff. An individualized transition plan was developed, and implemented for one of the individuals. It included a very systematic transition of his day and home activities, and staffing. This worked well for him and included input from transition staff and his IDT. This set of indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	228	126							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be	0% 0/2	0/1	0/1							

	trained and method of training required.										
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	50% 1/2	0/1	1/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	100% 2/2	1/1	1/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	50% 1/2	0/1	1/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments:

12. Assessments did not yet meet criterion for this indicator. The APC had sent out repeated reminders regarding the required content of the transition/discharge assessments that included most of the criteria listed below. This was a positive step. The Monitoring Team noted that the reminder indicated the summary section should consist of information that was the most recent (i.e., within one year). The individual's history of health, safety, and behavioral risks should also be represented, however, as there may be a recurrence in a new environment that can be addressed quickly if the provider is aware and prepared. The Monitoring Team considers four sub-indicators when evaluating compliance.

- Assessments updated with 45 Days of transition: The Center did not review or update the Integrated Risk Rating Form (IRRF) for these 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 #228, not all assessments were updated within 45 days of transition. The social and audiological updates were completed in February 2017, approximately 90 days prior to transition. The Center did not provide a vision assessment. This was of concern because the nursing assessment noted staff needed to check to see if he had an optometry appointment for updating his prescriptive lenses. For Individual #126, the Center did not provide a pharmacy or audiology update, but the remaining assessments were all timely.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: On a positive note, the social, psychiatric, habilitation therapies, and behavioral updates for both individuals were good examples of a summary of history and relevant facts. Vocational summaries were brief, however, and did not provide the needed level of detail. Individual #228's dental assessment did not provide details about his history of refusals.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not meet criterion for this indicator. Missing assessments were factored into this determination, but even assessments that had been updated did not consistently provide recommendations to support transition. Examples are included under the next bullet.

- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not address/focus on the new community home and day/work settings. Assessment recommendations varied considerably in comprehensiveness and individualization. The social assessment recommendations were good examples of an individualized approach to recommendations that would both assist in a successful transition and focused on the new settings. Examples of assessments that did not meet criterion for recommendations included:
    - The psychiatry assessment recommendations for both individuals were not individualized.
    - Individual #126's behavioral health assessment recommendations were very broad, such as to continue the PBSP.

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

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: The Lufkin SSLC included a specific section in both CLDPs to address the training of community provider staff, including the staff to be trained and level of training required, which was a positive practice and helpful in assessing this indicator. It did not, however, define the specific competencies provider staff needed to have to serve these two individuals, or how those would be demonstrated. Findings included:

- The Monitoring Team requested and reviewed the training documentation, including the training and testing materials. The material provided in response to this request was a spreadsheet training roster documenting provider staff trainee names for a group of individuals who had transitioned. It did not include information for Individual #228 and Individual #126.
- Transition staff indicated the Center was working with DADS central office on an initiative to enhance competency-based training documentation. The Monitoring Team requested and reviewed the material, a PowerPoint presentation. It included instructions about using a roster, as noted in the previous paragraph, to document competency-based training at the Center, including transition-related training. It further included details about various ways competency could be demonstrated and included a requirement that competency demonstration materials be attached to the roster. It was good to see the Center working toward developing a systematic approach to competency-based training and defining some expectations toward that end. The success of this initiative, for transition purposes, will rely heavily on the ability of the IDTs to specify what needs to be included in each individual's training, who needs to be trained, and how competency will be determined and documented.
- Per the transition log for Individual #228, inservices were completed for home staff and the workshop staff during his pre-placement visit on 3/15/17 and included the Profile, PBSP, and diet. The transition log also stated that during the CLDP on 4/18/17, the APC asked the provider if they would like for Lufkin SSLC staff to provide secondary inservices and they stated they did not have new staff and that additional inservicing was not needed. The provider further agreed to be responsible for inservicing all new staff, PRN staff, or to retrain any existing staff who need a refresher after Individual #228 transitioned to their care.
- As noted above, Individual #126's CLDP did not provide specific information about required training or pre-move training supports. The transition log contained a similar statement about the provider not requiring any secondary inservices.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: Both CLDPs provided a specific statement regarding the need for collaboration and, for both individuals, the statement called for an interaction to take place between the Center and provider nurses prior to the transition and for a post move support collaboration between psychiatry and psychology if the need arose. In both instances, the CLDPs did include a related pre-move support for the nurse-to-nurse collaboration, but only Individual #126's included a formal post-move support about the psychiatry and psychology collaboration.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results. Both CLDPs included a specific statement regarding this need.

17. The CLDP should include a specific statement of the IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. The Center had developed a positive practice of including a specific section of the CLDP to address this requirement, but it did not focus on the types of activities specified above.

- For Individual #126, the transition log and other documents detailed a transition plan that included direct support staff spending time with home and day habilitation staff prior to the move. This was good to see and his CLDP met criterion as a result.

18. LIDDA participation: These two CLDPs met criterion. It was positive to see the participation of the LIDDA in both pre-and post-transition activities.

19. The Pre-Move Site Reviews (PMSRs) were completed in a timely manner and indicated that all supports were in place. For both individuals, due to the lack of comprehensive pre-move training and competency testing supports, the PMSR failed to document that provider staff had knowledge of important health and safety needs that should have been clearly in place at the time of transition. For Individual #228 and Individual #126, the PSMR indicated only that a provider staff had been designated to provide in-service to all new staff at the home and day program.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: Once referred, the transitions of individuals at Lufkin SSLC receive ongoing attention. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	228	126								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 2/2	1/1	1/1								

Comments:

20. Both CLDPs met criterion for this indicator.
    - Individual #228 was referred on 3/8/16 and transitioned on 5/10/17. The Transition Log provided substantial detail about the transition process, which was helpful. The transition did not move forward between April 2017 and July 2017 due to Individual #228's incarceration and pending charges, but transition staff continued to actively engage with the appropriate parties during this period.
    - Individual #126 was referred on 9/14/16 and transitioned on 1/18/17, which was within 180 days.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted 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