United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

Dates of Onsite Review: November 12th to 16th, 2018

Date of Report: February 12, 2019

Submitted By:	Maria Laurence, MPA Alan Harchik, Ph.D., BCBA-D Independent Monitors
Monitoring Team:	James M. Bailey, MCD-CCC-SLP Victoria Lund, Ph.D., MSN, ARNP, BC Edwin J. Mikkelsen, MD Susan Thibadeau, Ph.D., BCBA-D Teri Towe, B.S. Scott Umbreit, M.S. Wayne Zwick, MD

Table of Contents

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

In the executive summary of the last report, the Monitors wrote about a variety of concerns related to individuals' engagement in activities, opportunities for out-of-home activities, untreated behavioral and mental health issues, and general cleanliness and quality of the homes, furnishings, etc. Since then, the Center put into place a detailed action plan that addressed Center-wide and individual-specific issues. A report/update was shared with the Monitors each month. The Monitors acknowledge the seriousness with which the Center's administration took these concerns, as well as the team effort in which staff across the Center engaged to implement the beginnings of the change process.

Examples of changes observed during this review that have had a positive impact included the following:

- Environmental changes occurred in some homes, with plans to continue improvements across campus.
- Some individuals (e.g., Home 6360) were more engaged, and strategies had been implemented to teach individuals to wear clothing.

- Intensive behavioral supports were increased in some homes, including the assigning a behavioral health services specialist to work hands-on with individuals and their staff. More than 80% of the staff assigned to work with almost all individuals had been trained on the individuals' PBSPs. Vocational and activity center staff had also received training. Throughout the week, Board Certified Behavior Analysists (BCBAs) were observed spending time in homes, providing support to both individuals and to staff.
- There was training on orientation and mobility techniques for individuals who were blind, and the initial development of specialized supports for these individuals.
- There were some improvements in the numbers of individuals sharing bedrooms, although many of the homes continued to serve large numbers of individuals.

In this report, 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 Abilene SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Center Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

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

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management; abuse, neglect and incident management; pretreatment sedation/chemical restraint; mortality review; and quality assurance. Nineteen of these indicators were moved to, or were already in, the category of less oversight after the last review. Presently, five additional indicators will move to the category of less oversight in the area of restraint and incident management.

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

Abilene SSLC maintained an already low trend in the frequency of use of crisis intervention restraint. The average duration of a crisis intervention physical restraint was among the lowest in the state, at less than one minute.

With the new Safe Use of Restraints (SUR) and Ukeru programs, the Center staff are knowledgeable about their application, restrictions, and documentation requirements. Suggestions are provided in the report below regarding the Center's implementation of the Ukeru program.

The Center provided a review of the usage of non-chemical restraint, pre-treatment sedation (PTS), and total intravenous anesthesia/general anesthesia (TIVA/GA) for the conduct of medical and dental procedures. They reported that intrusiveness of supports had moved from TIVA/GA to PTS for some individuals.

Non-nursing documentation regarding crisis intervention restraint was very good. There was one minor issue: the proper recording of Incident Management Review Team (IMRT) review (the Center acknowledged this during our onsite meeting). Post restraint review documentation was very good. This included the Center's Office Clinical Notes.

Since the implementation of the new restraint techniques, State Office and nursing administration at Abilene SSLC had not updated policy/procedures and nursing guidelines to incorporate any new or different expectations for nursing assessment. This should be done as soon as possible. Some of the additional areas in which nursing staff need to focus with regard to restraint monitoring include: providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; conducting and documenting follow-up for injuries or other abnormal findings; and providing information in Integrated Progress Notes (IPNs) related to, for example, the reason(s) for the restraint, and the assessment completed to determine whether or not the individual experienced an injury.

Abuse, Neglect, and Incident Management

Overall, incident management practices and the consequent management of abuse/neglect, incidents, and injuries deteriorated since the last review. This was likely due, in large part, to the absence of an on-campus Incident Management Coordinator (IMC). The Center was without

an IMC since July 2018 and likely will not have an IMC onsite again until January 2019. This is most likely the reason for regression in the Center's performance in incident management and management of abuse and neglect. The Monitoring Team recommends that the Center consider seeking support from the State Office discipline coordinator. Moreover, once there is an onsite IMC, there will likely be a lot of catch-up work to do. The Center administration should plan ahead for this.

Overall, there was regression in performance on many indicators. Two indicators that were previously moved to the category or requiring less oversight might be moved back into the category of active monitoring if improvements are not seen at the time of the next review (indicators 6 and 7). The investigation review process was not detailed and thorough, and, as a result, was not identifying problems, such as inconsistencies between information in Health and Human Services Commission Provider Investigation (HHSC PI) reports and information in the related Center Unusual Incident Report (UIR).

In half of the investigations, there were problems with timely reporting. The incident management department was not looking closely at the circumstances of the incident and whether someone should have reported earlier.

Relevant evidence was not always collected. That is, UIRs identified staff involved in the incident, but these staff were not interviewed (or there was no notation as to why they were not, or did not need to be interviewed).

Incident management department reviews of investigations were not thorough and detailed. They did not catch most of the problems identified by the Monitoring Team.

There was one investigation chosen for review that was a clinical referral back to the Center. There was no investigative activity conducted by the incident management department, and only some by the clinical investigation process. There were no recommendations and no follow-up actions.

Other

IDTs were discussing pretreatment sedation. In the selected examples, the teams determined that PTS was the best approach.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: Abilene SSLC maintained low usage of crisis intervention restraint and improved review of the usage of interventions for the conduct of medical and dental procedures. For the second consecutive review, all 12 of the data set sub-indicators of indicator 1 met criteria (i.e., 100%). These indicators remain in active monitoring. Comments are provided below regarding the Ukeru program for the Center's (and the State's) consideration.			Individuals:								
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549

1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	100% 12/12	This is a facility indicator.									
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	92% 11/12	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (February 2018 through October 2018) were reviewed. Overall, Abilene SSLC again had a decreasing trend in the usage of crisis intervention restraint. The Center now had the second lowest census-adjusted rate in the state (other than Austin SSLC). The frequency of usage of crisis intervention physical restraint paralleled the overall usage of crisis intervention restraint because almost all usages were crisis intervention physical restraint. The average duration of a crisis intervention physical restraint also continued to decline, to less than one minute. There was one usage of crisis intervention chemical restraint, which was in February 2018. There were three usages of crisis intervention mechanical restraint (wristlets) for one individual (Individual #199). This plan for usage was assessed by her IDT and was in her crisis intervention plan (CIP).

There were no individuals with protective mechanical restraint for self-injurious behavior (PMR-SIB). There were about the same number of individuals each month who had one or more crisis intervention restraints when compared with the last review. The staff said that, with the new SUR protocol, some interventions were now counted as restraint that were not previously counted (e.g., arm neutralization). Two non-serious injuries during restraint application were reported; these were based on information in the face to face documentation (also below see the outcome/indicators regarding nursing assessments post-restraint).

The Center put together a report looking at the usage of interventions to assist individuals with the completion of medical and dental procedures. This was a good first step to looking at these four data sets concurrently and in an integrated manner. For non-chemical restraints for medical procedures, there were no usages of mechanicals. The usage of physical was for one individual (Individual #93) and the frequency had declined over the review period, in part, due to the recent availability of a less intrusive glucose monitoring device. For dental, there were some usages of physicals in conjunction with pretreatment sedation. The number of individuals who received pretreatment sedation for medical procedures was showing a descending trend. For dental procedures, the number was 16. The Center was starting to look at moving individuals from requiring general anesthesia/TIVA to less intrusive pretreatment sedation. The number of individuals receiving GA/TIVA remained about the same. The dental director provided a list of individuals who no longer needed GA/TIVA and instead could be treated with pretreatment sedation. It would be good to incorporate these data into the Center's review of the overall usage of these procedures.

Thus, facility data showed low/zero usage and/or decreases in 12 of these 12 facility-wide measures (overall use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; duration of physical restraint; restraint-related injuries; number of individuals who had crisis intervention restraint; use of PMR-SIB; use of non-chemical restraint; and use of pretreatment sedation and TIVA/general anesthesia).

Note: Crisis intervention restraint should be used when there are imminently dangerous circumstances for which the staff need to intervene with crisis intervention restraint to protect the individual and others from immediate and serious risk of harm. Although the Monitoring Team looks for decreasing trends in the usage of crisis intervention restraint, appropriate usage of crisis restraint does not

prevent the Center from moving forward towards substantial compliance with the protection from harm restraint aspects of the Settlement Agreement.

Additional notes regarding restraint usage at Abilene SSLC:

- Ukeru-documentation: The BHS director reported that the use of Ukeru in response to behavioral crisis was now documented in the electronic data collection system. During the onsite visit, staff were observed using the Ukeru blocking pads with Individual #93. The data that were provided indicated the time at which the use of the pads was initiated, the location, and the reason. There was no information regarding the duration of use or the repeated presentation of the pads.

  Ukeru-equipment: Ukeru blocking pads were saliently present in homes and day program sites. Something to consider is that if these have been used with an individual during a crisis situation, their presence may be intimidating or serve as an unintended threat. It might be helpful to discuss this issue with individuals who can express their response to this recently introduced intervention. It would also be helpful to carefully observe individuals for any adverse response to the constant display of the blocking pads.

  Ukeru-injuries: Staff are also advised to carefully document any injuries that may result from the use of the blocking pads. During the onsite visit, there was contradictory information regarding Individual #231's possible injury following a crisis in which Ukeru strategies were employed. Nursing reported that Individual #231 had fallen backwards after running into a Ukeru pad. Individual #231 was complaining that her back hurt, she couldn't get up, and she had scratches on her knee. While the nurse didn't indicate that the injuries were the result of the crisis intervention, the note itself suggested this. When BHS staff were asked about this, the response was that no injury had occurred as a result of the use of the Ukeru pads.

- Restraint reduction committee follow-up: Minutes from the Restraint Reduction Committee meetings noted the Individual #549 was the most frequent aggressor on her home. Actions to address this included a meeting of her IDT in August 2018. When the ISPA minutes were requested, the facility provided her QIDP Monthly Review. It remained unclear whether her team had ever met.

2. Two of the individuals selected for review by the Monitoring Team were subject to restraint. The Monitoring Team also reviewed a medical restraint, series of physical restraints, and a mechanical restraint for three other individuals. Of these five individuals, three received crisis intervention physical restraints (Individual #93, Individual #231, Individual #530), one received crisis intervention mechanical restraint (Individual #199), and two received medical restraint (Individual #93, Individual #456). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for all but one individual (Individual #530). The other seven individuals selected by the Monitoring Team had no restraints making a total of eight of the 10 individuals meeting the criteria for this indicator.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.	
Summary: Crisis intervention restraint continued to be implemented and documented correctly. Indicators 7, 8, and 11 maintained high performance over	Individuals:

this and the previous two reviews, too, receiving 100% scores with only some exceptions. However, please see comments below regarding indicator 11 and the need for more detail in the IRRF. Therefore, these three indicators will be moved to the category of requiring less oversight. Indicator 9 will remain in active monitoring.											
#	Indicator	Overall Score	93	231	199	530	456				
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.										
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.										
7	There was no injury to the individual as a result of implementation of the restraint.	100% 6/6	2/2	1/1	1/1	1/1	1/1				
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 6/6	2/2	1/1	1/1	1/1	1/1				
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	100% 1/1	Not rated	Not rated	Not rated	1/1	Not rated				
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 6/6	2/2	1/1	1/1	1/1	1/1				
Comments: 11. There should be, but wasn't, some brief statement in the IRRF indicating that the team considered individualized possible contra-indications for the individual, that is, for example, that the team looked at the active problem list (e.g., how osteoporosis might affect the usage or prohibition of restraint).											

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.	
Summary: One staff did not know the SUR-prohibited procedures, individual restrictions, or when to terminate a crisis intervention restraint. This was the first time any staff member did not correctly answer Monitoring Team questions regarding restraint since 2015. Thus, the Center should take actions to ensure staff are knowledgeable given all of the new restraint intervention protocols that have been initiated (i.e., SUR, Ukeru). This indicator will remain in the category of less	Individuals:

oversight.											
#	Indicator	Overall Score									
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments:											

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: Indicator 13 was scored at 100% for the first time. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	93	231	199	530	456				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 4/4	1/1	1/1	1/1	1/1					
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A									
Comments:											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.	
Summary: Since the implementation of the new restraint techniques, State Office and nursing administration at Abilene SSLC had not updated policy/procedures and nursing guidelines to incorporate any new or different expectations for nursing assessment. This should be done as soon as possible. Some of the additional areas in which nursing staff need to focus with regard to restraint monitoring include: providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; conducting and documenting follow-up for injuries or other abnormal findings; and providing information in Integrated Progress Notes (IPNs) related to, for example, the reason(s) for the restraint, and the assessment completed to determine whether or not the individual experienced an injury. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	93	231	199	530	456				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	33% 2/6	0/2	0/1	0/1	1/1	1/1				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	50% 3/6	0/2	0/1	1/1	1/1	1/1				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	50% 3/6	0/2	0/1	1/1	1/1	1/1				

Comments: The restraints reviewed included those for: Individual #93 on 9/29/18 at 12:36 p.m., and 8/9/18 at 6:13 p.m. (medical: accuchek); Individual #231 on 5/4/18 at 3:33 p.m.; Individual #199 on 7/10/18 at 1:03 p.m. (mechanical: wristlets); Individual #530 on 8/11/18 at 11:12 p.m.; and Individual #456 on 9/6/18 (dental).

a. through c. For Individual #530's restraint on 8/11/18 at 11:12 p.m., and Individual #456's restraint on 9/6/18 (dental), the nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individuals.

In addition to the two restraints listed in the paragraph above, for the following restraint, nurses documented whether or not the individual sustained restraint-related injuries or other negative health effects, and took action as necessary to meet the needs of the individual: Individual #199's restraint on 7/10/18 at 1:03 p.m. (mechanical: wristlets).

The following provide examples of problems noted:

- For Individual #93's restraint on 9/29/18, the Center did not provide IView documents, but rather a Flowsheet that did not indicate which staff member filled in the information, or which nurse conducted the assessment. In addition, without the IView information, the Monitoring Team could not determine if all assessments were included on the Flowsheets as compared to the IView data. Some assessment information was cut off of the Flowsheet, but the Monitoring Team was able to determine that the nurse timely assessed the individual. In its comments on the draft report, the State disputed this finding, and stated: "See document request **TX-AB-1811-I.50.j.1**: Any related nursing flow/data sheets… The I-View is the restraint flow sheet. Please revise or explain why this is not sufficient." In the draft report, the Monitoring Team clearly explained why it was not sufficient.

  The Center submitted an IPN for this episode, but the nurse did not document the reason why the individual required restraints (arm neutralization) other than to say the individual pulled staff's hair, identify where it took place, or note her status, mobility, or presence of any injury. The nurse described mental status as "no change from baseline," which is not a specific enough mental status. A PCP order was obtained. The discipline's monitoring requirements for arm neutralization procedure were not found/available. As a result, the Monitoring Team referenced the requirements for a physical restraint.
- For Individual #93's restraint on 8/9/18, the assessment data was cut off of the Flowsheet provided. The State disputed this finding, and said that "This document was provided in its entirety with no cut offs from 08/09/2018 1812 – 08/09/2018 1816." However, information was cut off. This has been an issue at many Centers, and State Office reportedly is working on a fix to expand the text boxes on the printed version of the documents.

No nursing documentation was found regarding why the restraint was needed or why a full set of vital signs could not be obtained since the IPN noted she was "awake and alert." The State also disputed this finding, and stated: "Page 5 of the electronic document provided is nursing progress note title "Restraint requested for administration of insulin and accucheck" by [staff member]. Subjective documentation states: "S: TR notified of need for restraint at 1810 **after {#93} refused accucheck 4 times.**" As illustrated in the State's comments, although an IPN existed, the nurse had not documented a justification for the restraint (i.e., what were the individual's behaviors that required the use of restraint? "Refusing" accuchek does not provide the needed justification).

The nurse made no mention of the presence/absence of injuries in an IPN or did not indicate the individual's reaction or behavior during the restraint.

- For Individual #231's restraint on 5/4/18, an IPN, dated 5/14/18, at 4:50 p.m., indicated that the individual was complaining that her lower back hurt, and she was not able to get up. She also had abrasions on her left knee and left toe, and a red area on the left side of her neck. The nurse's IPN did not indicate that these injuries were from her running into the Ukeru blocking pad and falling backwards, as indicated in the Behavioral Health Office Clinic Note, dated 5/17/18 at 11:40 a.m. The nurse's IPN noted that the PCP ordered Tylenol for pain. However, no additional IPNs were provided to show follow-up assessments of her injuries. Regarding orders from the PCP, the Center documented in response to the request: "There were no orders obtained for these unsuccessful restraints." During onsite discussion with staff, nurses indicated that since Ukeru is not considered a restraint, an order would not be obtained. Based on the documentation submitted, it was unclear if the use of Ukeru ended as soon as the individual fell backwards, if staff moved her in light of a potential injury to her back, and/or how soon the nurse arrived to assess her. Staff need to document an overall description of what occurred during the use of Ukeru procedures in order to determine the type and level of nursing assessment that might be needed, particularly in light of individual's identified risk areas (e.g., cardiac risk, respiratory risk, etc.). The individual's mental status not documented on Flowsheets.
- The restraint for individual #199 began at 1:03 p.m., and ended at 1:14 p.m. It was not until 1:52 p.m. that a nurse conducted an initial assessment.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
Summary: 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	93	231	199	530	456				
15	Restraint was documented in compliance with Appendix A.	100% 6/6	2/2	1/1	1/1	1/1	1/1				
Comments:											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	93	231	199	530	456				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	75% 3/4	1/1	0/1	1/1	1/1					
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 4/4	1/1	1/1	1/1	1/1					
Comments: 16. For Individual #231 5/14/18, the IRIS form did not show date of IMRT review. The review occurred, but it must also be documented properly in the IRIS system. 17. For each restraint incident, there was a very good post restraint ISPA review, including a document titled Office Clinic Notes.											

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:			Individuals:								
#	Indicator	Overall Score									
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
48	Multiple medications were not used during chemical restraint.										
49	Psychiatry follow-up occurred following chemical restraint.										
Comments:											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: About one-third of the incidents did not have full supports in place to have reduced the likelihood of the occurrence of the incident. This included IDT reviews and actions, updating plans, teaching appropriate alternative behaviors, and implementing plans. This indicator will remain in active monitoring. Performance on this indicator was lower than any of the previous four reviews.			Individuals:								
#	Indicator	Overall Score	479	557	526	231	537	368	301	520	
1	Supports were in place, prior to the allegation/incident, to reduce risk	64%	2/3	1/1	1/2	1/1	1/1	0/1	1/1	0/1	

	of abuse, neglect, exploitation, and serious injury.	7/11									

Comments:
The Monitoring Team reviewed 11 investigations that occurred for eight individuals. Of these 11 investigations, seven were DFPS investigations of abuse-neglect allegations (one confirmed, two unconfirmed, three inconclusive, one clinical referral). The other four were for facility investigations of serious injuries (fracture, laceration), a sexual incident, and an unauthorized departure. 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 #479, UIR 26956, HHSC PI 47102168, unconfirmed allegation of neglect, 6/9/18
- Individual #479, UIR 31663, HHSC PI 47432173, inconclusive allegation of physical abuse, 9/12/18
- Individual #479, UIR 31969, sexual incident, 9/19/18
- Individual #557, UIR 31083, HHSC PI 47415932, inconclusive allegation of physical abuse, 8/28/18
- Individual #526, UIR 31097, HHSC PI 47416546, inconclusive allegation of physical abuse, 8/31/18
- Individual #526, UIR 23991, serious injury, laceration, discovered, 3/31/18
- Individual #231, UIR 29010, HHSC PI 47381480, unconfirmed allegations of physical and sexual abuse, 7/29/18
- Individual #537, UIR 31570, HHSC PI 47428794, confirmed allegation of neglect, 9/11/18
- Individual #368, UIR 29132, HHSC PI 47382072, clinical referral of an allegation of physical abuse, 8/6/18
- Individual #301, UIRs 29135 and 29136, unauthorized departure and law enforcement contact, 8/6/18
- Individual #520, UIR 26815, serious injury, fracture femur, discovered, 6/11/18

1. For all 11 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For all investigations, criminal background checks and duty to report forms were completed and available for review.

For four individuals, protections were not in place to have reduced the likelihood of the incident occurring in the first place.

- For Individual #479 UIR 31969, there was no training for staff to know how to teach more appropriate social behavior to the individual, even though this was part of the PBSP. Further, the Monitoring Team could not find any evidence of implementation, either via documentation or observation.
- Individual #526 UIR 23991 had 10 non-serious injuries in the last year, with no information about these and how they might have been related to this serious injury. Further, he had a PBSP, but no information was provided regarding how his behavioral health issues might have been related to this incident.
- The Individual #368 UIR 29132 case was regarding medication administration. He had a history of missed medications and significant weight loss. There was no documentation (e.g., ISPAs, nursing care plan) regarding these issues.

- For Individual #520 UIR 26815, proper implementation of the PNMP was not occurring at as high a level as it needed to be as per documentation and observation by the Monitoring Team.

One individual (Individual #231) was identified for streamlined investigations due to a history of making allegations that turned out to be spurious/purposely falsely made. Documentation showed that APS protocols were followed in making this determination. Similarly, the Center had procedures in place to address/reduce these false allegations.

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

Summary: Performance declined considerably from previous reviews. The Center needs to attend to meeting the various reporting requirements when there is an allegation of abuse/neglect and/or injury. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 479	557	526	231	537	368	301	520	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	45% 5/11	0/3	1/1	2/2	1/1	0/1	0/1	1/1	0/1	

Comments:

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

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

- Individual #479 UIR 26956: The incident occurred on 6/9/18 and was reported to DFPS Intake on 6/14/18. The UIR stated that the alleged victim of this individual's behavior told the nurse about it (page 3 of UIR). The UIR, however, did not explain why this was not reported (by the nurse) at that time, either to DFPS Intake or to the incident management office. It should have been immediately reported (at least to IMC office) so that a preliminary investigation could have been conducted to determine if neglect was suspected and, if so, should have been reported to DFPS Intake.
- Individual #479 UIR 31663: Per the UIR on page 4, the incident occurred at 6:48 pm. Per the HHSC PI report, it was reported to DFPS Intake at 8:02 pm. The UIR said that the reporter was unknown, but both the UIR and HHSC PI identified the eyewitness who should have immediately reported. The UIR showed facility director/designee notified at 7:28 pm. The UIR didn't explain any of these discrepancies.
- Individual #479 UIR 31969: Per the UIR on page 4, the incident occurred at 4:28 pm and was reported at 5:31pm, slightly more than the one hour time limit.
- Individual #537 UIR 31570: This was reported promptly to DFPS Intake after Individual #537 was found outside with no clothes on (in the middle of the night). The UIR showed that the reporter was unknown. But video camera recordings confirmed that he had walked out approximately two hours earlier. Per the HHSC PI report, they did not notify the facility

director/designee until 8:20 am, approximately four hours after having received the report. The UIR showed that facility director notification was at 8:49 am. There was nothing in the UIR showing AOD notification soon after the report was made to DFPS Intake, or explaining this discrepancy.

- Individual #368 UIR 29132: Although the report was listed as unknown, the reporter evidently knew of the missed medication and this should have been reported earlier.
- Individual #520 UIR 26815: Per the UIR on page 20, the director's call was not made and the reporting procedures were not followed. However, the Monitoring Team saw other information (e.g., on page 4) that showed more proper reporting. With conflicting data, the Monitoring Team could not determine if proper reporting occurred.

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: For indicator 4, sub-indicator .2, regarding the IDT/ISP review and discussion about abuse, neglect, and injuries, in general, the summaries/analyses were well done, especially the one done for Individual #537.			Individuals:								
#	Indicator	Overall Score									
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.										
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.										
Comments:											

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.	
Summary: There were problems with the provision of protections in two cases. The Center, needs to improve its incident management processes in this area to return to the higher performance demonstrated during the previous four reviews and for this indicator to remain in the category of requiring less oversight. • Individual #479 UIR 31663: The Center was notified on 9/14/18 of the identified alleged perpetrator. The alleged perpetrator was not re-assigned until 9/18/18. There was nothing in the UIR to explain this delay. • Individual #368 UIR 29132: Aspects of this incident related to immediate protections were not done by the incident management department. That	Individuals:

	is, there was nothing in the UIR to indicate that the Center attempted to identify the alleged perpetrator or conduct an investigation of alleged abusive actions. The case was closed the same day it was received from HHSC PI, 8/6/18.											
#	Indicator	Overall Score										
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
	Comments:											

Outcome 5– Staff cooperate with investigations.												
Summary: In two cases, relevant witnesses/alleged perpetrators were reported to be avoiding interview or not available (Individual #557 UIR 31083, Individual #537 UIR 31570). This was never an issue in the previous four reviews and is another area in need of attention by the incident management department and improvement needs to occur for this indicator to remain in the category of requiring less oversight after the next review.			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: 7. In its response to the draft version of this report, the State described the process that HHSC PI typically uses for contacting witnesses for interview. The delays were not noted in the HHSC PI report, or by the IMC in review of the investigation.											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary: The quality and thoroughness of investigations decreased compared with the last two reviews. Primarily, but not solely, there were problems with obtaining all relevant evidence and information because not all staff were interviewed. This was a problem at the time of the last monitoring review. At that time, the Center had a process in place to address missing interviews. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	479	557	526	231	537	368	301	520		
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was	91% 10/11	3/3	1/1	2/2	1/1	1/1	0/1	1/1	1/1		

	utilized.										
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	45% 5/11	1/3	0/1	1/2	1/1	1/1	0/1	1/1	0/1	
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	45% 5/11	1/3	0/1	1/2	1/1	1/1	0/1	1/1	0/1	

Comments:

8. For Individual #368 UIR 29132, the Monitoring Team could not determine if a thorough investigation was completed. First, an investigation of possible abuse by clinical staff was not investigated by the incident management department or by HHSC PI. Second, the Monitoring Team could not determine if a thorough investigation was conducted as per the SSLC protocol for responding to an allegation referred back as a clinical referral. It appeared that some, but an insufficient amount, of investigative activity was conducted as part of the clinical investigation process. For instance, there were no recommendations and no follow-up activities.

9-10. For five cases, there were problems with obtaining all relevant evidence from staff who were involved in the incident (Individual #479 UIR 26956, Individual #479 UIR 31663, Individual #557 UIR 31083, Individual #526 UIR 31097, Individual #520 UIR 26815). In one case, staff who were interviewed described their physical management of the individual, but this was not explored with habilitation staff as to whether staff were providing supports correctly (Individual #520 UIR 26815). And, in one case, a thorough investigation was not conducted (Individual #368 UIR 29132).

Without interviewing all staff identified as involved, insufficient evidence was obtained and analyzed from which to draw a conclusion. In instances of an inconclusive finding, there is an expectation of Center investigatory follow-up to see if the Center can develop additional information that might allow for a possible/more likely confirmed or unconfirmed finding.

In response to the draft version of this report, the State commented on two of the investigations. First, regarding Individual #479 UIR 26956, the State wrote that sufficient evidence was gathered to show there was no neglect on the part of a staff member. Even so, the UIR identified a number of staff in the involved party section of the report. When staff are identified as involved, they should be interviewed, either as part of the HHSC PI investigation, or as part of the Center's follow-up to an unconfirmed finding. If not interviewed, the reason should be noted in the UIR. Second, regarding Individual #479 UIR 31663, the State wrote that HHSC PI interviewed all relevant staff members involved in the allegation and staff members were cooperative with the investigation. Given that this was an inconclusive finding regarding physical abuse, there was limited effort to try and reconcile contradictory testimony from the alleged perpetrator and another staff person (e.g., attempts to obtain a statement from alleged victim as to what happened). Additionally, there was no evidence in the UIR that the Center conducted substantive investigatory activity after receiving the HHSC PI report to try and figure out if they could come to a conclusion other than inconclusive.

Outcome 7– Investigations are conducted and reviewed as required.	
Summary: At the time of the last review, Abilene SSLC had a very good investigation review process. That was not occurring at the time of this review. At the last review, indicator 13 scored 100%. The Center needs to look at its overall	Individuals:

investigation management program. Indicator 13 will remain in active monitoring.											
#	Indicator	Overall Score	479	557	526	231	537	368	301	520	
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.	36% 4/11	1/3	0/1	1/2	1/1	0/1	0/1	1/1	0/1	
Comments: 13. The Center's investigation review process did not detect the many problems identified by the Monitoring, such as regarding late reporting, missing interviews, and absence of investigation components. 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: Non-serious injury investigations were not always conducted when they should have been, and those that were conducted did not include a response to the important question as to whether abuse/neglect was suspected. Indicator 15 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	479	557	526	231	537	368	301	520	
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, this indicator was 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.	25% 2/8	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	
Comments: 15. For three of the individuals, some non-serious injuries occurred that were not subjected to the non-serious injury investigation											

process, but should have been. For four of the individuals, non-serious injury investigation documentation was not fully completed. Specifically, the documentation for about half of the NSI investigations reviewed by the Monitoring Team did not indicate a yes/no response to the query regarding whether abuse/neglect was suspected. The two individuals who were scored positively for this indicator did not have any non-serious injuries that met criteria for requiring a non-serious injury investigation.

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

Summary: Performance scores were lower for indicators 16 and 18 compared with the last two reviews. They will remain in active monitoring. On the other hand, disciplinary and programmatic action implementation met criteria for all relevant investigations for this review and the last three reviews, too, with one exception for each. Therefore, indicators 17 and 18 will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	479	557	526	231	537	368	301	520	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	86% 6/7	3/3				1/1	0/1	1/1	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 2/2	1/1				1/1				
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 6/6	3/3				1/1		1/1	1/1	

Comments:

16. For Individual #368 UIR 29132, an investigation should have generated some recommendations.

17. There were three cases in which there was a confirmation of physical abuse category 2. In both cases, the confirmed staff members' employment was terminated.

18. For Individual #479 UIR 31663, there was no evidence regarding the blocking pad recommendation.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.

Summary: This outcome consists of facility indicators. Abilene SSLC had a thorough report that contained a lot of data. The Center was beginning to create goals based upon their data. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score									

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

Comments:
19. All seven data sets were being tracked and trended.

20. The report contained a lot of data. Adding some type of an Executive Summary that highlights the positive areas and those areas most in need of improvement might be useful.

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	100% 1/1									1/1

Comments: a. 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. For example, the Dental Department policy entitled: "Dental Sedation and General Anesthesia," dated 10/19/18, listed five criteria for the use of anesthesia, but did not meet criteria. For example, it did not require at least three trials in the office setting. Similarly, with regard to medical clearance, the Medical Department at ABSSLC did not have its own policy, but submitted a copy of the State Office Policy: "Medical Care," Policy Number 009.2, effective 5/15/13. This policy did not include any information/guidance concerning medical clearance for dental procedures under TIVA/GA. 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 this use of general anesthesia, informed consent was present, nothing-by-mouth status was confirmed, an operative note defined the procedures and assessment completed, and nurses completed post-operative vital sign flow sheets.

b. Based on the documentation provided, for the one individual reviewed for whom Center staff administered oral pre-treatment sedation for dental work, staff followed proper procedures.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	33% 1/3	N/A	1/3	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. Based on the documentation provided as part of the Center's response to the Tier I document request, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for medical procedures. However, based on documentation provided as part of the Center's response to the Tier II document request, the Monitoring Team discovered that Individual #93 received pre-treatment sedation on 6/26/18 for a podiatry appointment. In addition, she received it on 10/2/18 for an ophthalmology appointment and electrocardiogram (EKG), and on 10/9/18 for a podiatry appointment, which was after the cutoff for Tier I information. However, the Center's response to the Tier I document request should have included the 6/2/18 use, and this failure to provide accurate information about medical pre-treatment sedation in the Tier I documents was concerning.

For the last two uses of pre-treatment sedation, the medical restraint plan was over a year old, and the most recent ISP, dated 8/16/18, did not discuss sedation for medical appointments. No ISPAs were found showing IDT input to the PCP with regard to the medication and dosage range. Informed consent was present for each administration, and nurses documented pre- and post-administration vital signs.

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: IDTs were discussing pretreatment sedation. In the selected examples, the teams determined that PTS was the best approach. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	479	93	526						
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses	100% 3/3	1/1	1/1	1/1						

	the five topics.										
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.	100% 3/3	1/1	1/1	1/1						
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A									
4	Action plans were implemented.	N/A									
5	If implemented, progress was monitored.	N/A									
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A									

Comments:
1-2. Three of the nine individuals had pretreatment sedation over the past 12 months. These were Individual #479, Individual #93, and Individual #526. For each of these individuals, their IDTs had reviewed the need and effectiveness of pretreatment sedation, the risk versus benefit of treatment with PTS versus without, and other supports that could be offered in the future. The teams determined that it would be counter-therapeutic to take actions and that PTS was the best approach.

3-5. Each of the individuals had a Medical Restraint Plan at the time of the PTS, with evidence of informed consent from their LAR and the facility's Human Rights Committee. Individual #479's MRP had expired, but his IDT had met in August 2018 and determined that this was not necessary at that time. Staff are advised to ensure that all consents are obtained prior to plan implementation.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	297	233	345	462					
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require	0% 0/4	0/1	0/1	0/1	0/1					

	improvement.										
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

Comments: a. Since the last review, 10 individuals died. The Monitoring Team reviewed four deaths. Causes of death were listed as:

- On 2/9/18, Individual #76 died at the age of 78 with causes of death listed as pulmonary hypertension, congestive heart failure, and left bundle branch block with diastolic dysfunction.
- On 2/17/18, Individual #297 died at the age of 39 with causes of death listed as respiratory failure with pleural effusion, bacterial pneumonia, and Influenza A.
- On 2/18/18, Individual #349 died at the age of 59 with causes of death listed as terminal congestive heart failure with respiratory failure, and aspiration pneumonia.
- On 3/18/18, Individual #233 died at the age of 79 with causes of death listed as acute respiratory failure, interstitial lung disease, pulmonary edema, and chronic lung disease.
- On 4/1/18, Individual #345 died at the age of 87 with causes of death listed as advanced dementia, and brain damage with intellectual disability.
- On 4/25/18, Individual #75 died at the age of 63 with cause of death listed as chronic hypercapnic respiratory failure.
- On 5/11/18, Individual #552 died at the age of 52 with causes of death listed as respiratory failure, septic shock, peritonitis, and small bowel obstruction with volvulus.
- On 5/21/18, Individual #462 died at the age of 75 with causes of death listed as suspected cardiac arrhythmia, and coronary atherosclerosis.
- On 6/15/18, Individual #403 died at the age of 71 with causes of death listed as acute renal failure, bacteremia with sepsis, and colonic volvulus.
- On 10/12/18, Individual #429 died at the age of 71 with the preliminary cause of death listed as an acute myocardial infarction.

b. through d. Between and within disciplines, great variability was noted in the comprehensiveness of the death reviews. However, overall, evidence was not submitted to show the Center conducted thorough reviews of healthcare, or an analysis of disciplines' 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 strengths and weaknesses include:

- For Individual #297, the Center provided a Nursing Clinical Death Review, dated 3/2/18. The Center did not provide a Quality Improvement Death Review of Nursing Services and provided no explanation for its absence. In the Nursing Clinical Death Review, much effort was put into organizing the information, and the review produced some valuable findings. For example, the review identified: a lack of provider notes addressing labs/diagnostics reviewed in the clinic, a lack of respiratory therapy

documentation of an assessment, a lack of assessments before and/or after the administration of pro re nata (PRN, or "as needed" medications), nursing staff not documenting the implementation of nursing guidelines, issues when IRIS went down and nurses had to document medications given on paper Medication Administration Records (MARs), and then, the lack of "back-charting" when access to IRIS became available. However, the nurse conducting the review made no recommendations related to these findings. For many of the issues, Center staff provided no verification that they had taken any actions to address them.

- For Individual #233, an RN completed a Nursing Clinical Death Review, dated 4/3/18, and an RN completed a Quality Improvement Death Review of Nursing Services, dated 3/29/18. Neither of these reports included the title of the RN completing the review.

  The lengthy (71-page) Nursing Clinical Death Review included the individual's Active Problems, a review of the IRRF and IHCP, significant labs and diagnostics, and review of six months of IPNs. Clearly, a great deal of effort and organization was invested in this review and the nurse identified a number of problematic areas, which was potentially valuable to the Center's quality improvement processes. For example, direct support professionals replaced an oxygen cannula, which they should not have done, and they did not report this to nursing staff; nursing staff entered incomplete subjective, objective, assessment, and plan (SOAP) notes; nursing staff did not follow up on medical issues; nursing staff entered identical IPNs that referred to IView assessments that were not found; nursing staff did not take and/or document the individual's vital signs for pain assessments, etc. However, for most of these findings, the Clinical or Administrative Death Reviews did not include recommendations, and, as a result, it was not clear that staff took actions to address and monitor these issues. In addition, the RN had not conducted a review of the IRRF and IHCP, but rather merely listed them in the report.

  Although the Quality Improvement Death Review of Nursing Services was not a comprehensive review, it identified some additional issues. For example, on three medication orders, the PCP listed the wrong route for the medications, and low rates of staff's compliance were noted regarding bed positioning for the individual. No specific recommendations were generated from this review.
- For Individual #345, the Center provided a Death Review, dated 4/19/18, that an RN Nurse Manager completed. Although not a comprehensive review, some of the issues identified included nursing staff not initiating the implementation of nursing guidelines in a timely manner, and nurses' notes not including oral intake related to signs and symptoms of dehydration. No recommendations were generated from these findings.

  The QA nurse completed a Quality Assurance Death Review of Clinical Services, dated 4/19/18. Although it was not a comprehensive review, it identified that there were"462 missed opportunities for observation documentation in Care Tracker for the past 90 days prior to [Individual #345's] death," ''82 missed shift documentations for bowel activity," and "50 missed meal documentations" of which 12 were for breakfast. An order was in place for staff to notify the PCP if the individual refused more than 50% of his breakfast, which would affect his blood sugar and dose of Insulin. Based on these concerning findings, no recommendations were generated in the QA Death Review report. However, based on other documentation submitted, a recommendation was implemented for retraining the direct support professionals in the home on their responsibility for documenting in Care Tracker each shift. However, documentation indicated that the supervisor was to run reports in IRIS for 90 days regarding the personal care documentation and report findings to the Unit Director, but no data were provided

addressing this monitoring process.

In addition, neither of the nursing reviews addressed the delay of 20 minutes between the time staff initiated cardiopulmonary resuscitation (CPR) and the time staff called 911. The Administrative Death Review Committee Report indicated that: "By the time CPR began and EMS arrival and transfer [sic], the total time was just under an hour."

- For Individual #462, the Center provided the Quality Assurance Death Review of Clinical Services, dated 6/6/18, which was very brief and provided little, if any, review or recommendations. The variations in the Center's nursing reviews of deaths over approximately a two-month period of time was concerning.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "develop a process to ensure documentation of consideration of asthma treatment guidelines in IRIS," resulted in the six PCPs signing a statement that read: "see UpToDate article: 'An overview of asthma management' on line for available CME [continuing medical education] and excerpt attached." 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 medical staff considered and documented their consideration of current asthma guidelines for individuals with this diagnosis.

The response to the Clinical Death Review recommendations for Individual #462 was not sufficient to ensure that individuals received the medical supports they needed. More specifically, in response to recommendations to address the need to develop a process to better track the completion of electrocardiograms (EKGs) to ensure the scheduling of appointments and documentation of the results or individuals' refusals, the Center submitted a statement that read: "Nursing service already has a process in place to track and follow up on all consults which would include EKGs that are ordered. Spreadsheet is monitored by the RNCM [Registered Nurse Case Management] supervisor as well as the nurse manager as part of their weekly rounds. No further actions will be taken in this matter." Based on the findings of the death review, this system was not working. Further response was necessary, such as additional training of staff, additional supervision of RNCMs' implementation of the system in place, and/or development of a different system.

The Center did not submit documentation to show that the recommendation for Individual #233 was implemented. The recommendation read: "Review of chart identified documentation in IRIS DSP [direct support professional] reapplied oxygen to the individual but there is a facility policy which prohibits this action. Rec develop a process to ensure DSP complete appropriate documentation of notification of nursing staff in IRIS when individuals required immediate intervention."

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.	
Summary: For the two individuals reviewed who experienced ADRs, staff reported them timely, PCPs took the necessary clinical actions, the P&T Committee reviewed them, and Center staff reported both to MedWatch, because they met criteria. The Center's performance on these indicators has varied. They will remain in active oversight.	Individuals:

#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	ADRs are reported immediately.	100% 2/2	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	100% 2/2	1/1	1/1							
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 2/2	1/1	1/1							
d.	Reportable ADRs are sent to MedWatch.	100% 2/2	1/1	1/1							

Comments: a. through d. For Individual #30, a lab, dated 4/30/18, showed increased alkaline phosphatase. On 5/17/18, when the lab was repeated and the levels were still elevated, the PCP discontinued atorvastatin. On 7/20/18, a follow-up lab showed the level returned to normal. The PCP prescribed a lower dose of the medication, but even at the lower dose, the alkaline phosphatase level increased. The PCP discontinued the medication. On 8/21/18, the P&T Committee discussed the ADR. On 9/5/18, Center staff submitted the ADR to MedWatch.

On 4/17/18, Individual #93 had a severe reaction to Bactrim, and nursing staff notified the PCP. The individual was hospitalized, and a dermatologist saw her. She was treated with Niacin for 30 days. On 5/15/18, the P&T Committee reviewed the ADR, and on 5/17/18, Center staff submitted it to MedWatch.

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: N/A		
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	

Comments: a. and b. None.

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. Twenty-four of these were moved to, or were already in, the category of requiring less oversight after the last review. Presently, five additional indicators will move to the category requiring less oversight. These are in the areas of ISPs, psychiatry, psychology, and Occupational/Physical Therapy (OT/PT). This includes the entirety of Outcome #9 in psychiatry.

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

Assessments

For half of the individuals, IDTs considered what assessments the individual needed and would be relevant for the ISP prior to the annual meeting. Almost all IDTs did not arrange for and obtain all of these needed, relevant assessments prior to the meeting.

Psychiatry attended almost all of the annual ISP meetings. When psychiatry does not attend, there needs to be some justification.

Eight of the nine individuals had a current behavioral health assessment. The functional behavior assessment (FBA) was complete for eight of the nine individuals.

Seven of the nine individuals had current Functional Skills Assessments, Preferences and Strengths Inventories, and vocational assessments. The assessments for seven of the nine individuals included SAP recommendations.

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

Medical Department staff should continue to focus on improving the timely completion of annual medical assessments. It was positive that six of the nine individuals reviewed had quality annual medical assessments. PCPs should continue to make improvements with regard to plans of care.

For eight of nine individuals, PCPs completed no interval medical reviews. This issue needs to be corrected as soon as possible. In addition, ISPs/IHCPs need to define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

It was positive that for the individuals reviewed, the dental exams and dental summaries included all of the required components.

For eight out of nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments, which was good to see. For three of nine individuals reviewed, problems were noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments.

For six of the nine individuals reviewed, nurses completed annual and quarterly physical assessments that addressed the necessary components. Work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to their at-risk conditions. In addition, when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice.

Many of the individuals reviewed should have had Physical and Nutritional Management Team (PNMT) reviews or assessments, but did not. The one comprehensive PNMT assessment reviewed included some of the necessary components, but did not include a thorough review of the individual's current supports to identify where changes might be needed, and/or use data to identify the etiology of the individual's PNM issues. Without thorough reviews/assessments, comprehensive plans to address the underlying causes of the individuals' PNM issues could not be developed and implemented.

A significant issue was that Center staff had not followed the current guidelines for considering when an OT/PT comprehensive assessment should be repeated. For a number of individuals reviewed, the three-year mark had passed, and OTs/PTs had not completed a new comprehensive assessment, or provided individualized clinical justification for why an update met the individual's needs. In a number of cases, OTs/PTs concluded that the individual's status was accurately reflected in the three- to four-year-old assessment, despite considerable evidence to the contrary. In addition, the assessments reviewed needed considerable improvement.

Significant work is needed to improve the quality of communication assessments in order to ensure that Speech Language Pathologists (SLPs) provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated.

Individualized Support Plans

The Center focused on environmental improvements and additional staff training on supporting individuals. Some homes were more welcoming and less chaotic. Many examples were observed of positive staff interactions with individuals in homes and day sites.

The Center made various environmental changes since the last visit. Renovations had occurred in several areas, notably Home 6360 and Activity Center 5971, 5972, and 5973. The individuals living in Home 6360 were more engaged and strategies had been implemented to teach individuals to wear clothing.

The Qualified Intellectual Disabilities Professional (QIDP) department implemented several new processes that should lead to further improvements in the ISP process, including additional review of ISPs, a new PSI peer review process, and a monthly review monitoring process.

It was good to see that Abilene SSLC could generate good, measurable goals. On the other hand, at this point, this should be occurring for more (if not all) goal areas. In addition, similar to the other Centers, good goals were not yet developed for the health and wellness/IHCP areas for each individual.

Across all individuals in the review group, five of the goals had action plans that were likely to lead to the accomplishment of the goal. Action plans were not implemented within a timely basis for any of the individuals.

Most ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT. However, few individuals had a thorough examination and discussion of living options that might meet their needs and preferences.

In psychiatry, Abilene SSLC made good progress towards creating individualized psychiatric indicators and goals. This is evident in the 2/2 scores for some individuals for indicators 4 and 5 (and some 1/2 scores, too). The psychiatry team had a good understanding of these indicators (i.e., psychiatric indicators, goals, documentation, data) and had a plan to continue to move forward. Psychiatry's annual ISP documentation was complete for all individuals.

In behavioral health, there was noticeable improvement in the assessment of the reliability of PBSP data. Not all measures yet showed that PBSP data were reliable, but it was good to see that the Center now had a system to determine this.

For the first time, some of the PBSPs met all of the criteria for content (i.e., they included all of the required components). Further, BHS staff were participating in helping address some problems that were not necessarily part of a PBSP. And, throughout the week, there was evidence of BCBAs spending time in homes, providing support to both individuals and to staff. This was particularly evident in Home 6360 and Home 6400.

In skill acquisition, there was improvement in that so many of the SAPs had reliable data.

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 plans.

Some improvement was noted with regard to the inclusion in IHCPs of physical and nutritional management (PNM) triggers, as well as definition of monitoring/review of progress. Overall, though, more work was needed to ensure that ISPs/IHCPs comprehensively set forth plans to address individuals' PNM needs. In addition, regression was noted with regard to the quality of PNMPs. Staff should focus on clearly connecting triggers to the risk areas to which they apply.

It was good to see that the IDTs of individuals reviewed approved PNMPs/positioning schedules as part of the ISP process, including providing a brief summary of any changes. The related indicator is moving to the category requiring less oversight. IDTs of individuals reviewed also did a good job of including in annual ISPs the OT/PT strategies, and interventions, and programs recommended in assessments, but due to problems with assessments, IDTs did not have comprehensive sets of recommendations to consider. In addition, IDTs need to include in ISPs concise, but thorough descriptions of individuals' OT/PT functional statuses.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: Performance remained about the same. So, once again, it was good to see that Abilene SSLC could generate good, measurable goals. On the other hand, at this point, this should be occurring for more (if not all) goal areas. In addition, similar to the other Centers, good goals were not yet developed for the health and wellness/IHCP areas for each individual. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	437	93	231	145	187			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	1/6	4/6	3/6	2/6	3/6	1/6			
2	The personal goals are measurable.	0% 0/6	1/6	3/6	2/6	0/6	2/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #93, Individual #30, Individual #231, Individual #437, Individual #145, and Individual #187. 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 Abilene SSLC campus.

1. The ISP relies on the development personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish.

Although not part of the criteria for this indicator, personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

IDTs were struggling to develop good vision statements for individuals. This led to the development of goals with no clear purpose or priority for the individual. Rarely were goals aspirational. In particular, work and day goals were not meaningful or functional. Rather than being aspirational or providing opportunities to learn new skills, day goals typically related to compliance with attending solely the on-campus day or work sites.

None of the six individuals had individualized goals in all six goal areas. Therefore, none had a comprehensive set of goals that met criterion.

For this set of individuals, however, the IDT had defined/chosen some personal goals that met criterion for being individualized, based on the individual's preferences and strengths. Overall, 14 of 36 personal goals met criterion for this indicator. This was a decrease from 16 at the last review.

The IDTs might make better use of the ISP preparation meeting, such as using the meeting to discuss how the IDT can use the subsequent three months to explore various aspects of supports and services to then include in the annual ISP. Personal goals do not need to be identified at the ISP preparation meeting.

Goals that met criterion were:

- Individual #93's goals for recreation/leisure, relationships, and greater independence.
- Individual #30's goal for greater independence.
- Individual #231's goals for recreation/leisure and relationships.
- Individual #437's goals for recreation/leisure, relationships, greater independence, and living options.
- Individual #145's goals for recreation/leisure, relationships, and greater independence.
- Individual #187's relationship goal.

IDTs had created the above goals (that were more individualized and based on known preferences), however, although not rated for indicator 1, few had specific teaching strategies to ensure staff were implementing them and measuring success consistently, and 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.

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

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

3. None 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, for all of the other goals, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of data and documentation provided by the Center. While there were some data collected showing implementation of some action plans, there was not enough information documented to clearly determine the status of goals.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: Performance remained low. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	437	93	231	145	187			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	1/6	2/6	0/6	2/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	33% 2/6	0/1	0/1	1/1	0/1	1/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	67% 4/6	0/1	1/1	1/1	1/1	1/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the	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	1/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	2/6	0/6			

Comments:

8. Fourteen of the personal goals met criterion in the ISPs, as described above in indicator 1, therefore, those action plans could be evaluated in this context. A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

Five of the goals had action plans that were likely to lead to the accomplishment of the goal. The following goals had reasonable action plans to support these goals:

- Individual #93's recreation/leisure and greater independence goals.
- Individual #437's recreation/leisure goal.
- Individual #145's recreation/leisure and relationship goals.

Although this was an improvement from the last review, for the most part, IDTs were not developing action steps that would lead to measurable progress towards goals.

Skill acquisition programs did not include enough information to ensure that staff could consistently implement them and determine what progress was made. Most of the action plans were written as service objectives and did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress. Many action plans stated what staff would do, but not what action the individual would take to show progress towards accomplishing his/her goal thus data often indicated how many times staff had implemented the plan instead of measuring specific progress towards the goal.

9. Two of the ISPs had action plans that integrated preferences and opportunities for choice.

- Individual #93 had action plans based on her preferences. Her action plans to choose her clothing and snack gave her some

opportunities to make choices and have some control over her day. The IDT, however, had not assessed her preferences in regard to work.
- Individual #145's action plans addressed his known preferences for music and sporting events. He had an action plan to develop a daily schedule that allowed him to make some choices regarding his daily schedule.

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

10. None of the ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. A basis to making informed decisions is offering individuals exposure to a variety of new experiences and opportunities to make choices throughout their day. These opportunities were rarely included in action plans in any substantial way.

11. Four of the ISPs met criterion for this indicator to support the individual's overall independence. This included:
- Individual #231 had action plans learn self- management of her medication and diet. She also had an action plan to create a calendar of activities to give her some control over her daily schedule.
- Individual #93's action plans shower and shop in the community were designed to give her greater independence.
- Individual #437's action plans to make his own snack and develop a daily schedule provided him with greater independence.
- Individual #145's action plan to turn on his game system and propel himself in his wheelchair provided him with opportunities to learn to be more independent.

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

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

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. Individual #231's ISP did integrate recommendations from her nutritionist and behavioral support plan into action plans to support her goals. Some examples of this lack of integrated supports included:
- Individual #93's day programming goals did not include recommendations regarding her health, mobility, communication, or behavior.
- Individual #30's communication assessment noted that she had the ability to learn to use at least 20 signs. The team requested input from the SLP on developing action plans related to communication, however, QIDP monthly reviews indicated that action

plans had not yet been developed.

- Individual #145 had a number of recommendations from his OT and SLP that had not been integrated into his action plans.

14. Individual #437 had the only ISP that included action plans to support meaningful integration into the community. His action plans to participate in a community recreation program and visit a local coffee shop should lead to developing relationships in his community, however, his plans were not being implemented consistently. Meaningful and substantial community integration action plans were absent from five of the ISPs, with no specific, measurable action plans for community participation that promoted any meaningful integration.

Individuals made frequent trips into the community, but were rarely given opportunities to utilize community resources that might support them to be more independent and integrated into the community. Individuals did not have goals for banking, volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movie, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. ISPs did not include action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Day and work opportunities were particularly limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting.

Training opportunities were limited and rarely individualized. Individuals had few opportunities to learn new skills and experience new things.

16. For the most part, ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional skill development. During observations, activities were rarely functional and did not provide opportunities to experience new things and learn new skills. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests.

- Individual #93's action plans to attend the workshop daily appeared to be a compliance goal rather than a skill building opportunity. Staff reported that she was routinely attending the workshop and folding towels. Her ISP Preparation document indicated that she knew how to complete the laundry contract, but often refused to attend work. Observation did not support functional skill building at the sheltered workshop that might lead to working in a more integrated setting. Additionally, she was only scheduled to attend the workshop in the mornings.
- Individual #30 was scheduled to attend the sheltered workshop 4.5 hours per week and the senior program an additional four hours per week. Her ISP did not include action plans for functional skill building at either day site.
- Individual #231 had one skill acquisition plan to complete a job application during day programming. The IDT had not identified her preferences for work outside of the few job contracts offered at the sheltered workshop.
- Individual #437's ISP included minimal opportunities for functional training during the day. His attendance at day programming was on hold due to a broken finger, so he was spending his days at home.
- Individual #145's ISP indicated that he would attend the activity center during the day, however, his plan failed to identify

meaningful skill building opportunities for him at the day site.

- Individual #187's ISP also failed to define how he would spend his day in meaningful activities and what skills he might learn during day programming. During observations, he was not engaged in skill building activities.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Goals were not consistently implemented, and IDTs did not address barriers to implementation. A review of ISP preparation documents indicated that some goals that either had not been implemented or the individual failed to make progress were continued from the previous ISP without addressing barriers. None of the ISPs addressed identified barriers to community transition.

18. Action plans did not describe detail about data collection and review, in almost all cases. Overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated, not individualized, and, in most cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented. The two action plans that did meet criteria were Individual #145's action plans for recreation/leisure and his relationship goal.

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

Summary: All relevant indicators were met for one individual (Individual #93). ISPs included information about the individual's preferences for all but one individual in the review group for this and the previous three reviews, too. Therefore, indicator 19 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 30	437	93	231	145	187			
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).	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	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	1/1	1/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	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 community).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	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	0/1	1/1	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.	N/A									
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/4	0/1	0/1			0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A									

Comments:

19. Five ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT.
    - Individual #187 had lived at the facility since 1979. His ISP noted that he had little exposure to community living options. The IDT stated that visiting other living options would not be beneficial because he would not realize where he was at or why he was there. Although in the past, his LAR had expressed her wishes that he would continue to live at Abilene SSLC, the team had not been in contact with her over the past year. The ISP did not include a description of environmental preferences based on what the team knew about Individual #187.

20, 25, and 27. There were no annual ISP meetings scheduled for the week of the review.

21. Four ISPs included the opinions and recommendation of the IDT's staff members.
    - Individual #187's annual medical exam was not submitted prior to the ISP meeting for team consideration. His PCP did not attend his ISP meeting to offer input. The IDT determined that he had health issues that would be a barrier to living in the community.
    - Individual #437's annual medical exam was submitted too late for the IDT to review and his PCP did not attend his annual ISP meeting to provide input on his medical support needs.

22. Five ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. The IDT had not been in contact with Individual #187's LAR over the past year.

23. One of the individuals (Individual #93) had a thorough examination of living options based upon their preferences, needs, and strengths. Otherwise, ISPs did not document a discussion of available settings that might meet individual's needs.

24. All ISPs identified a list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed.

26. One of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified. Individual #93's IDT identified her brittle diabetes and sporadic eating habits as barriers to living in the community. She had action plans to increase her independence in monitoring her own health and diet. This was positive to see.

28. Individuals did not have individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs. This was not scored for Individual #93 and Individual #231 because the IDT did not identify a need for further education either for them or their LARs.

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

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.												
Summary: Relevant team members were missing from each individual's ISP meeting. ISPs were not implemented within the time requirement. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	30	437	93	231	145	187			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.										
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6	1/1	1/1	0/1	0/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

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

33. Four individuals attended their ISP meetings. Individual #93 and Individual #231's ISPs indicated that they did not attend their annual meetings.

34. None of the individuals had an appropriately constituted IDT based on the individual's strengths, needs, and preferences, who participated in the planning process.

- Individual #93, Individual #30, Individual #437, and Individual #187 all had complex medical needs. Their PCP did not attend the annual ISP meetings.
- Individual #231's behavioral health specialist did not attend her meeting. Her ISP indicated that behavior was a barrier to accomplishing most of her goals.
- The speech therapist did not attend Individual #437 or Individual #145's ISP meeting. They both had significant communication needs. In response to the draft version of this report, the State wrote that representatives from the habilitation therapy department attended both meetings. Although it was good that the Center made attempts to have relevant representative attendance, communication recommendations were not ultimately integrated into action plans for these two individuals. Given that both had significant communication needs, when the SLP was unable to attend the ISP meeting, he or she should review action plans developed by the IDT at the meeting and ensure that teaching strategies include individualized recommendations for communication. In both cases, input from the SLP would have greatly benefited the IDT.

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

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

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

Summary: Most assessments were identified, except for vocational. All assessments, however, were not obtained. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 30	437	93	231	145	187			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	50% 3/6	0/1	1/1	0/1	0/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			

Comments:

35. For three individuals, IDTs 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.

- Individual #93, Individual #30, and Individual #231 needed a more comprehensive vocational assessment that might identify other work skills and preferences.

36. Five IDTs did not arrange for and obtain all needed, relevant assessments prior to the IDT meeting.

- Individual #30's annual medical assessment, functional skills assessment, and OT/PT assessment were submitted late.
- Individual #231's vocational assessment was not updated and her speech assessment was submitted late.
- Individual #437's annual medical assessment, dental assessment, and functional skills assessment were submitted late.
- Individual #145's behavioral assessment was not timely.
- Individual #187's annual medical assessment, behavioral assessment, functional skills assessment and day assessment were not submitted timely.

Without relevant assessments for the IDT to review, it is unlikely that comprehensive supports and services were developed, and all risks were addressed.

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

Summary: IDTs were meeting monthly, which was good to see, but some incidents required a more timely review. QIDP monthly reviews were occurring regularly; also good to see, but the quality of the reviews needed improvement. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	30	437	93	231	145	187			
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 monthly to review supports, services, and serious incidents, however, QIDP were not always documenting that incidents were discussed in a timely manner outside of that monthly review. For example,

- Individual #93 had a serious injury on 8/30/18. The QIDP did not document a review of that incident until her monthly meeting on 9/4/18. She was involved in a peer-to-peer aggression incident on 9/11/18 and on 9/19/18. A review of these incidents was not documented until the monthly meeting on 10/4/18.
- Individual #30 was involved in peer-to-peer aggression incidents on 7/13/18, 7/21/18, 7/31/18, and 8/4/18. The QIDP did not document review of these incidents until the monthly IDT meeting on 8/20/18.
- Individual #145 was hospitalized 9/14/19 through 9/19/18. The QIDP did not document a team meeting following hospitalization until his routine monthly review on 10/11/18.

IDTs did not routinely revise supports or goals or address barriers when progress was not evident.

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

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

Some QIDP monthly reviews included data for some action plans, but rarely include an analysis of those data to determine what specific progress had been made towards achievement of goals. Information regarding behavioral supports, habilitation therapy, and medical supports was inserted in the monthly reviews without a summary of status, statement on the efficacy of supports, or efforts made to follow-up on outstanding issues. There was little documentation of follow-up when plans were not implemented or not effective. This practice places individuals at significant risk for harm when the IDT cannot determine if supports to address risks are consistently implemented or effective.

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

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

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

#	Indicator	Overall Score	Individuals: 30	93	199	82	187	145	552	178	185
a.	The individual's risk rating is accurate.	17% 3/18	0/2	1/2	0/2	0/2	0/2	1/2	1/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	44% 8/18	0/2	1/2	1/2	1/2	1/2	1/2	1/2	1/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs to determine how IDTs addressed specific risk areas [i.e., Individual #30 – skin integrity, and other: sequelae from victimization related to peer-to-peer aggression; Individual #93 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #199 – falls, and weight; Individual #82 – falls, and constipation/bowel obstruction; Individual #187 – choking, and hypothermia; Individual #145 – constipation/bowel obstruction, and osteoporosis; Individual #552 – constipation/bowel obstruction, and choking; Individual #178 – skin integrity, and falls; and Individual #185 – UTIs, and constipation/bowel obstruction].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate,

provided clinical justification for exceptions to the guidelines were those for Individual #93 – UTIs, Individual #145 – osteoporosis, and Individual #552 – choking.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #93 – UTIs, Individual #199 – weight, Individual #82 – constipation/bowel obstruction, Individual #187 – choking, Individual #145 – osteoporosis, Individual #552 – choking, Individual #178 – skin integrity, and Individual #185 – UTIs.

Psychiatry

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

Summary: Abilene SSLC made good progress towards meeting the requirements of this set of indicators (and sub-indicators). This is evident in the 2/2 scores for some individuals for indicators 4 and 5, and the many 1/2 scores for those two indicators, too. The psychiatry team at the Center appeared to have a good understanding of these indicators (i.e., psychiatric indicators, goals, documentation, data) and had a plan to continue to move forward. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	25% 2/8	1/2	2/2	1/2	1/2	0/2	1/2	1/2	2/2	1/2
5	The individual has goals related to psychiatric status.	13% 1/8	1/2	0/2	1/2	2/2	0/2	1/2	1/2	1/2	1/2
6	Psychiatry goals are documented correctly.	0% 0/8	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments:
The scoring in the above boxes has a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase.

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

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

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

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors. These are the observable, measurable behaviors for reduction and for increase, respectively. They are hypothesized to be, for the most part, under operant control. A functional assessment is conducted to determine the variables that set the occasion for, and maintain, target behaviors (i.e., their function). Replacement behaviors are chosen to provide a functionally equivalent, more socially appropriate alternative to the target behavior. Replacement behaviors sometimes need to be taught to the individual. Many times, however, replacement behaviors are already in the individual's repertoire, in which case the task for the Center is to set the occasion for those replacement behaviors to occur, be reinforced, and maintained.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder.

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

The Monitoring Team looks for:

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

4a. Each individual had at least one indicator for reduction. The psychiatric treatment team had also formulated at least one psychiatric indicator for increase for each individual in the review group.

4b. The relationship between the psychiatric indicator for reduction and the individual's psychiatric diagnosis was clearly specified for six of the eight individuals. For Individual #93 and Individual #231, the descriptions of the derivation of the psychiatric indicator from the underlying psychiatric diagnosis were vague and non-specific. There was a plausible explanation of the linkage between the psychiatric indicator to increase and the psychiatric diagnosis for six of the eight individuals, that is, all except Individual #30 and Individual #93.

4c. The psychiatric indicators to decrease were described with specific observable terminology. The psychiatric indicator to increase was described in practical observable terminology for three of the eight individuals. For Individual #93, Individual #30, and Individual #549, the indicator to increase was primarily linked to attendance at program or involvement with activities. This was problematic

because their attendance and participation in activities could also be influenced by preference. The issues for Individual #526 and Individual #479 related to the complexity of the indicators, which would make them difficult to assess on a routine basis.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for six individuals. For psychiatric indicators for increase, the criteria met for three of the individuals. Overall, criteria were met for all three sub-indicators for both types of psychiatric indicators for two individuals (Individual #557, Individual #537).

5. Psychiatric goals:
The Monitoring Team looks for:

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

5d. The goals for decrease were recorded in the goal grids that appeared in the APTP and the Psychiatric Quarterlies. There were goals for the indicator to decrease for all of the individuals. The goals for the indicator to decrease for Individual #557, Individual #93, and Individual #231, however, did not specify an end date and, thus, did not meet the criteria. There was a goal for the indicator to increase for five of the individuals, that is, not for Individual #30, Individual #93, and Individual #549. For Individual #30 and Individual #549, the teams were still collecting baseline data, and goals had not yet been established. The issue with Individual #93 was that the criteria simply said increase and, thus, had insufficient information to be considered as a functional goal.

5e. For psychiatric goals for decrease, the type of data and how the data is to be collected was identified for all of the individuals. For goals for increase, the individuals for whom the data collection related to the goal was defined with sufficient clarity and with potentially observable behaviors were Individual #557, Individual #479, and Individual #231.

Thus, for indicators for reduction, both sub-indicators were met for five individuals. For indicators for increase, the two sub-indicators were met for two individuals. Overall, criteria were met for both sub-indicators for both types of psychiatric indicators for one individual (i.e., Individual #479).

6. Documentation:
The Monitoring Team looks for:

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

6f. The goals for reduction did not yet appear in an IHCP in the ISPs. The goals for increase did not appear in the IHCPs.

6g. The teams were still in the process of developing viable goals. Therefore, there are not goals from the prior year to be updated or modified. The psychiatry teams changed data collection methods for some individuals over the course of the year, but had not formally restated the goals.

Thus, for indicators for reduction and increase, indicator 6f was not met for any individuals. For all individuals, 6g was rated as not applicable.

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

The review of the psychiatric indicator and behavioral health target behavior data (for reduction and for increase) performed by the Monitoring Team indicated that the behavioral data were not reliable and, thus, could not be used to assess an individual's progress on their psychiatric goals.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Scores were about the same as at the last review. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 30	557	437	479	93	526	231	537	549
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.										
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 1/1		1/1							
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	50% 4/8	1/1	0/1		1/1	0/1	1/1	0/1	0/1	1/1

Comments:
15. Individual #557 was admitted within the prior two years. The records for this individual contained a CPE that had been done within 30 days of admission and an admission IPN that was done on the day of admission.

16. The psychiatric diagnoses were consistent in the behavioral health and psychiatric sections of the record for all the individuals in the review group. The diagnoses were not consistent in the medical section of the records for Individual #557, Individual #93,

Individual #231, and Individual #537.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: Psychiatry's annual ISP documentation was complete for all individuals as was the case for the previous three reviews, with one or two exceptions. Therefore, indicator 18 will be moved to the category of requiring less oversight. Psychiatry attended almost all of the meetings; when psychiatry does not attend, there needs to be some justification. Once that is included, indicator 20 might also be moved to the category of requiring less oversight. Indicators 20 and 21 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
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).	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	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.	88% 7/8	1/1	1/1		0/1	1/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	63% 5/8	1/1	0/1		0/1	1/1	0/1	1/1	1/1	1/1

Comments:

17. The psychiatric team prepared an annual Psychiatric Treatment Plan (APTP) for each individual prescribed psychotropic medications, prior to their annual ISP.

18. The information contained is the APTPs was comprehensive and met the content requirements.

19. These documents were prepared and submitted to the ISP team in a timely manner at least 10 days prior to the ISP.

20. A member of the psychiatric treatment team (either a psychiatric RN, psychiatric NP or the psychiatrist) attended the ISP for all of the individuals, except Individual #479.

In discussing this with the psychiatric team, the Monitoring Team learned that they had not attended Individual #479's ISP because at the pre-ISP the IDT had determined that psychiatry did not need to attend. Accordingly, a request was made for the minutes of the relevant pre-ISP meeting to determine the rationale for this decision. The notes from this meeting did not discuss any rationale for the decision and simply stated that psychiatry did not need to attend the ISP. In the context of earlier discussions with the direct care staff

on Individual #479's living unit, they indicated that he was on one-to-one staffing because of sexually inappropriate behavior. Thus, one would assume that this level of acuity would suggest that a member of the psychiatric team should be present at the ISP. In addition, the attendance sheet for the pre-ISP indicated that a member of the psychiatric team did not attend the pre-ISP during which this decision was made.

21. The ISP for five of the individuals met the content requirements.

Those for whom there were deficiencies in the documentation were Individual #557, Individual #479, and Individual #526. All of the ISPs contained a detailed description of the psychiatric medications, including their side effects. The deficits for the three individuals were in the areas of the integration between the psychiatric and behavioral aspects of the individual's presentation, the absence of adequate behavioral data, and an empirical justification that the medications represented the least intrusive/most positive interventions.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.												
Summary:			Individuals:									
#	Indicator	Overall Score										
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.												
Summary: Indicator 30 will be moved to the category of requiring less oversight due to sustained high performance.			Individuals:									
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.										
30	A risk versus benefit discussion is in the consent documentation.	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
32	HRC review was obtained prior to implementation and annually.										

Comments:
30. The consent documentation contained a risk versus benefit discussion for each medication.

Psychology/behavioral health

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

Summary: Individuals who needed a PBSP continued to have them and the goals and objectives were based upon their relevant assessments. This has been the case for all individuals for the previous two reviews, too. Therefore, indicator 4 will be moved to the category of requiring less oversight. There was noticeable improvement in the assessment of the reliability of PBSP data. This was very good to see. Not all measures yet showed that PBSP data were reliable, but it was good to see that the Center now had a system to determine this. Indicator 5 will remain in active monitoring. In addition, however, the Monitoring Team observed occurrences of PBSP target behaviors that never appeared in the individual's data.

#	Indicator	Overall Score	Individuals: 30	557	437	479	93	526	231	537	549
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4. Each of the nine individuals had measurable goals related to their psychological/behavioral health services and, in each case, these goals were based upon the individual's assessment. Licking objects and refusals were appropriately added to Individual #537's PBSP after his functional behavior assessment had been completed. Staff are advised to conduct a new FBA to ensure that the most appropriate treatment strategies are applied to these newly identified problem behaviors.

5. There was evidence that both inter-observer agreement and data timeliness were assessed regularly. While not all measures of data timeliness met the 80% or greater criterion over six months' time, there was observable improvement.

During the onsite visit, several individuals were observed engaging in problem behavior. Concerns were raised after their PBSP data were checked. Specific examples are outlined below. Some of the individuals listed below are not part of the review group.

- Individual #187 was observed engaging in multiple occurrences of self-injury at 4:30 pm on the Monday of the visit. No data were recorded.
- Also on Monday at 4:30 pm, Individual #537 removed his pants; this was not recorded.
- Individual #430 was observed throwing chairs at workshop at 9:10 am on Friday. This behavior was not recorded.
- Individual #93 was observed engaged in multiple occurrences of aggression at workshop on Thursday between 10:00 am and 10:30 am. Two occurrences of aggression were recorded, at 10:53 am and 10:54 am. Staff are advised to recheck the method of measurement because the PBSP suggests a frequency count is used to measure aggression, while the *Target Behavior Summary Web Report* suggests that episodes (separated by five minutes without) of aggression are recorded.

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

Summary: Performance on these behavioral assessment-related indicators continued to fluctuate. Attention to the details of the requirements (perhaps with some sort of clerical or QI support) could help move these indicators into sustained high performance. Indicator 11, however, with sustained high performance, might be moved into this category after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 30	557	437	479	93	526	231	537	549
10	The individual has a current, and complete annual behavioral health update.	33% 3/9	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:

10. Eight of the nine individuals had a current behavioral health assessment. The exception was Individual #549, whose BHA was completed in September 2017. (The Center, however, provided a draft updated BHA at the time of the document request.) Three of the nine individuals (Individual #557, Individual #93, Individual #231) had a complete BHA. For all others, there was no review of the individual's physical health over the previous year. With the exception of Individual #537, the degree of cognitive delay was noted, but unlike past reports, the tool used to assess cognitive abilities and the examiner were not identified.

11. The functional behavior assessment (FBA) was complete for eight of the nine individuals. The exception was Individual #549. An

updated FBA was included in her draft BHA. As noted in the SSLC Behavioral Health Services Policy, the Behavioral Health Assessment, one component of which is the FBA, is to be reviewed annually. The FBA provided in the October 2018 document request was completed in September 2017 and did not include an acceptable indirect assessment. An updated and complete FBA was included in her draft BHA.

12. The functional behavior assessment was considered complete for eight of the nine individuals. The exception was Individual #549. In Individual #549's FBA, there was no evidence of an indirect assessment being completed.

For many individuals, descriptive assessment was completed via videotape review. (In Individual #557's FBA, a video of an aggressive incident was reviewed, although it was included under indirect assessment.) While this is a good practice when there is an absence of problem behavior during in vivo observations, reliance on video review should be avoided because the assessment of all potential variables is limited due to the lack of audio and the limited visual field. An updated FBA is advised for Individual #537 because two new behaviors were added to his PBSP after the completion of his annual assessment.

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

Summary: For the first time, some of the PBSPs met all of the criteria for content (i.e., they included all of the required components). This was good to see. Even so, some attention to PBSP components was necessary, such as ensuring that target behavior definitions are not too broad. Further, BHS staff were participating in helping address some problems that were not necessarily part of a PBSP. Moreover, two-thirds were implemented as per indicator 13. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 30	557	437	479	93	526	231	537	549
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	67% 6/9	1/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1
14	The PBSP was current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	The PBSP was complete, meeting all requirements for content and quality.	33% 3/9	0/1	1/1	0/1	0/1	0/1		1/1	1/1	0/1

Comments:

13. The PBSP for six of the nine individuals was implemented within 14 business days of having attained all necessary consents. The exceptions were Individual #437 and Individual #526 whose plans were implemented later than 14 days following all consents, and Individual #537 whose plan was implemented before consent was obtained.

15. Three of the nine individuals (Individual #557, Individual #231, Individual #537) had a complete PBSP. All of the remaining six plans included the following required elements: operational definitions of target and replacement behaviors, antecedent strategies for

weakening undesired behaviors, and guidelines for training/strengthening replacement behaviors. The PBSP for Individual #549 included a range of good guidelines for how staff should interact with her based on the information provided in her BHA/FBA.

Findings regarding the other required elements are provided below:

- The use of positive reinforcement was addressed in every PBSP with the exception of Individual #30, Individual #437, and Individual #479. Individual #437's plan identified potential reinforcers, but provided no guidelines for their use.
- Consequent strategies were clearly outlined in all plans, with the exception of Individual #479. The intervention to address his inappropriate sexual behavior was not comprehensive, e.g., it did not include directions to respect his privacy by prompting him to his room, did not provide for time alone, etc.
- Sufficient opportunities for training/strengthening replacement behaviors were included in the PBSPs for everyone, but Individual #30, Individual #437, and Individual #479.
- Replacement behaviors were considered functional for everyone, but Individual #30, Individual #93, Individual #526, and Individual #549.
- With the exception of Individual #479's replacement behavior, treatment objectives were included in the PBSPs.

For two individuals, one of their target behaviors covered a range of very different responses. Individual #437's disruptive behavior was defined as stripping, self-injury, and refusing to get up off the ground. As stripping and self-injury can limit one's access to a range of environments and cause harm, respectively, it may be important to measure these separately. Individual #231's disruptive behavior was defined as stripping, tearing items, overturning furniture, threatening others, and property destruction. Here too, concerns are raised as some behaviors have the potential to cause harm to herself and/or others and limit her access to a range of environments. Additionally, the consequences were quite varied and included restitution and correction, which may require IDT and/or HRC considerations due to rights restrictions. When the issue of target behaviors being too inclusive was discussed with the BHS director, she acknowledged that staff were aware of this potential problem and were working on identifying and tracking individual responses.

When an individual begins to refuse participation in essential activities, (e.g., taking medication, completing hygiene routines, consuming meals in a safe manner, participating in scheduled work/day program), BHS staff should become involved in developing programs to address these needs. An example where this had occurred was when the IDT addressed Individual #30's participation in workshop. During the onsite visit, staff were observed using a visual timer (*Time Timer*) to note the passing of five minute intervals. As long as Individual #30 continued to work, she received a sip of coffee at the end of each interval. Staff reported that she was now staying for most of her scheduled shift.

Due to frequent aggression to Individual #284 by her peers, the Monitoring Team requested information on steps taken to address this problem. Documents indicated that most frequent incidents occurred between 4:00 pm and 6:00 pm, Monday through Friday. Staff were reminded to separate Individual #284 from those who were most likely to be aggressive and to try to direct her to less busy areas on the home, particularly those areas where she could listen to her radio. The BHS staff had conducted several observations in the home, some of which revealed little engagement and insufficient availability of preferred music. Her PBSP had been recently updated/revised and was implemented in October 2018. Strategies included providing Individual #284 the opportunity to eat her meal at the first sitting, keeping her engaged throughout the day (i.e., no more than 15 minutes without an attempt at active engagement), providing access to her favorite radio station, particularly during times when others are displaying disruptive behavior. It was good to

see these actions being taken to address this problem, however, it would be advisable to complete an updated assessment of her interests in recreational and work activities, and to repeat a preference assessment across a variety of items and activities. Lastly, it would be helpful to increase observations in the home and day program sites that include measures of engagement.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
Summary:			Individuals:									
#	Indicator	Overall Score										
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.											
Comments:												

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Medical Department staff should continue to focus on improving the timely completion of annual medical assessments. For eight of nine individuals, PCPs completed no interval medical reviews. This issue needs to be corrected as soon as possible. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	56% 5/9	0/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: c. For eight of nine individuals, PCPs completed no interval medical reviews. This issue needs to be corrected as soon as possible. In addition, 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." Interim reviews need											

to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim 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: It was positive that six of the nine individuals reviewed had quality annual medical assessments. PCPs should continue to make improvements with regard to plans of care. Indicators a and c will remain in active oversight.

#	Indicator	Overall Score	Individuals: 30	93	199	82	187	145	552	178	185
a.	Individual receives quality AMA.	67% 6/9	1/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that six individuals' AMAs (i.e., Individual #30, Individual #82, Individual #145, Individual #552, Individual #178, and Individual #185) included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. It was also positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, family history, social/smoking histories, childhood illnesses, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, pertinent laboratory information, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #30 – diabetes, and cardiac disease; Individual #93 – diabetes, and other: palliative care; Individual #199 – gastrointestinal (GI) problems, and weight; Individual #82 – falls, and seizures; Individual #187 – cardiac disease, and other: hospice care; Individual #145 – respiratory compromise, and GI problems; Individual #552 – constipation/bowel obstruction, and weight; Individual #178 – falls, and urinary tract infections (UTIs); and Individual #185 – respiratory compromise, and infections].

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: As indicated in the last several reports, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.

#	Indicator	Overall	Individuals: 30	93	199	82	187	145	552	178	185

		Score									
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.	20% 3/15	0/2	1/2	0/2	0/2	0/2	0/2	1/1	N/A	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% 0/15	0/2	0/2	0/2	0/2	0/2	0/2	0/1	N/A	0/2

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #30 – diabetes, and cardiac disease; Individual #93 – diabetes, and other: palliative care; Individual #199 – GI problems, and weight; Individual #82 – falls, and seizures; Individual #187 – cardiac disease, and other: hospice care; Individual #145 – respiratory compromise, and GI problems; Individual #552 – constipation/bowel obstruction, and weight; Individual #178 – falls, and UTIs; and Individual #185 – respiratory compromise, and infections).

The following IHCPs included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations: Individual #93 – other: palliative care, Individual #552 – constipation/bowel obstruction, and Individual #185 – respiratory compromise.

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: It was positive that for the individuals reviewed, the dental exams and dental summaries included all of the required components. If the Center sustains its performance with regard to dental summaries, after the next review, Indicator c might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									

	ISP meeting.										
	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	100% 7/7	1/1	1/1	N/R	1/1	N/R	1/1	1/1	1/1	1/1

Comments: For Individual #199 and Individual #187, a limited review was conducted. They were two of the five individuals reviewed who were edentulous (i.e., the others were Individual #30, Individual #93, and Individual #552).

b. It was positive that for the nine individuals reviewed, the dental exams included all of the required components, including the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- Sedation use;
- A summary of the number of teeth present/missing;
- Treatment provided/completed;
- An odontogram;
- A treatment plan; and
- Periodontal charting: The dental audit tool explains: "For individuals with periodontitis, if the individual did not have periodontal probing completed, this indicator will be marked as '0.' Dental Progress Notes or the description of cooperation section of the dental exam is where auditors would find documentation of any challenges and decisions to recall the individual to complete periodontal charting." Based on the documentation submitted, the Dentist had documented the reason, if any, for the decision not to complete at least annual periodontal probing. For all four individuals, for whom this was applicable (i.e., all others were edentulous), the Dentist indicated general anesthesia was needed to complete the procedure safely. As has been agreed with the with the State Office Dental Discipline Lead, the standards used for periodontal disease are those of the American Academy of Periodontology. As their website (i.e., https://www.perio.org/consumer/perio-evaluation.htm) states: "In 2011, the American Academy of Periodontology published the Comprehensive Periodontal Therapy Statement, which recommends that all adults receive an annual comprehensive evaluation of their periodontal health." Of course, IDTs would need to weigh the risks-benefits when sedation is required to complete the procedure. As a result of the documentation provided, the Monitoring Team scored the dental exams positively for each of these individuals.

c. It was very good to see that the seven dental summaries reviewed included the following:

- Effectiveness of pre-treatment sedation;
- Recommendation of need for desensitization or another plan;
- A description of the treatment provided (i.e., treatment completed);
- The number of teeth present/missing;
- Dental care recommendations;
- Dental conditions that could cause systemic health issues or are caused by systemic health issues;
- Treatment plan, including the recall frequency;
- Provision of written oral hygiene instructions; and
- Recommendations for the risk level for the IRRF.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.

Summary: For eight out of nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments, which was good to see. For three of nine individuals reviewed, problems were noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 30	93	199	82	187	145	552	178	185
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: a.i. and a.ii. Most of the individuals reviewed had timely annual comprehensive nursing reviews and physical assessments. However, for Individual #178, the dates covered in the "annual" nursing review were from 1/25/18 though 4/16/18, which was a quarterly, not an annual review.

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

- For Individual #30, the Center did not provide a quarterly review for the time period between June and August 2018.

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

Summary: For six of the nine individuals reviewed, nurses completed annual and quarterly physical assessments that addressed the necessary components. Work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to their at-risk conditions. In addition, when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 30	93	199	82	187	145	552	178	185
a.	Individual receives a quality annual nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	69% 6/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual receives a quality quarterly nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs;	69% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1

	vi. Pain; and vii. Follow-up for abnormal physical findings.										
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/10	0/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. As discussed above, Individual #178 did not have an annual nursing record review. It was positive that all of the remaining annual nursing record reviews included the following:

- Active problem and diagnoses list updated at time of annual nursing assessment (ANA);
- Social/smoking/drug/alcohol history;
- List of medications with dosages at time of ANA;
- Immunizations;
- Consultation summary; and
- Tertiary care.

Most, but not all included:

- Lab and diagnostic testing requiring review and/or intervention.

The components on which Center staff should focus include:

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

b. It was positive that for six individuals reviewed, nurses completed annual physical assessments that addressed the necessary components. Problems noted were related to lack of follow-up for abnormal vital signs, and an incomplete assessment of the gait of an individual who fell several times (i.e., Individual #82).

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #30 – skin integrity, and other: sequelae from victimization related to peer-to-peer aggression; Individual #93 – constipation/bowel obstruction, and UTIs; Individual #199 – falls, and weight; Individual #82 – falls, and constipation/bowel obstruction; Individual #187 – choking, and hypothermia; Individual #145 – constipation/bowel obstruction, and osteoporosis; Individual #552 – constipation/bowel obstruction, and choking; Individual #178 – skin integrity, and falls; and Individual #185 – UTIs, and constipation/bowel obstruction).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, on a positive note, for about a quarter of the risk areas reviewed, nurses included thorough status updates in annual assessments, including relevant clinical data (i.e., Individual #30 – skin integrity, Individual #93 – UTIs, Individual #145 – osteoporosis, and Individual #185 – UTIs, and constipation/bowel obstruction). Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year, and/or made

recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

For the following risk areas (approximately 40% of those reviewed), nurses included necessary updates in the most recent quarterly assessment: Individual #93 – UTIs; Individual #145 – osteoporosis; Individual #178 – skin integrity, and falls; and Individual #185 – UTIs, and constipation/bowel obstruction. Although this was movement in the right direction, nurses had not analyzed the information, or made necessary recommendations to IDTs.

d. For Individual #30, the Center did not provide a quarterly review for the time period between June and August 2018 (i.e., the most recent quarterly period). Therefore, all sub-indicators scored 0. It was positive that all of the remaining quarterly nursing reviews included:

- Active problem and diagnoses list updated at time of the quarterly assessment;
- List of medications with dosages at the time of quarterly nursing assessment;
- Immunizations;
- Consultation summary; and
- Tertiary care.

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

- Social/smoking/drug/alcohol history; and
- Lab and diagnostic testing requiring review and/or intervention.

The components on which Center staff should focus include:

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

e. It was positive that for six individuals reviewed, nurses completed quarterly physical assessments that addressed the necessary components. Problems noted were related to the lack of a quarterly nursing assessment for Individual #30, a lack of follow-up for abnormal vital signs for Individual #178, and inaccurate information about Individual #82's falls (i.e., it indicated no falls, but Document #TX.IV.1-20 noted four falls during the quarter).

g. The following provide 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 #30, nursing IPNs, dated 9/5/18, 9/6/18, 9/14/18, 9/17/18, 9/19/18, 9/22/18, 9/24/18, 9/26/18, 9/27/18, and 9/28/18, addressed a bump to the right side of the individual's head, but did not include a description of the bump, exact location of it, or if drainage or an open area was present. In addition, all of these IPNs were identical and provided no specific clinical information to indicate the level of healing over time. This is not accepted nursing practice.

  This practice of cutting and pasting or otherwise repeating identical IPNs without providing specific updates to clinical information was a recurring issue in the nursing IPNs reviewed for the individuals in the review group. Despite the fact that one of the Center's mortality reviews identified this as a concern, nursing/Center administration had not yet resolved the

problem. While onsite, the Monitoring Team discussed this issue with the Chief Nursing Executive (CNE), and provided examples of such IPNs from the documents submitted for the review group.

- For Individual #30, an IPN, dated 9/8/18, which addressed an incident in which a peer hit the individual in the head, did not include necessary details of the incident, where exactly on her head she was hit, or instructions to direct support professionals regarding what they needed to report, if changes in status occurred. In addition, the IPN, dated 9/10/18, regarding a peer hitting the individual on her head again was basically identical to the IPN, dated 9/8/18. In its comments on the draft report, the State disputed this finding, and reiterated IPNs that the Monitoring Team previously reviewed. It was unclear what the State's specific dispute was. The only change the Monitoring Team made to the original finding was to remove a statement that the IPNs did not show notification of a provider (i.e., the State's comments clarified that the use of the term "POC" meant "provider on call").
- An IPN, dated 8/5/18, at 9:01 a.m., indicated that Individual #93 had not had a bowel movement since 8/1/18. The nurse did not describe an assessment in the IPN, and it was not clear who actually gave the PRN suppository.

  In its comments on the draft report, the State disputed this finding, and stated: "The 08/05/2018 0901 IPN is a Provider On-Call 'POC' Communication narrative note and not a nursing assessment… The statement that the person had not had a BM [bowel movement] in 5 days and there was [sic] no assessments documented or the constipation protocol implemented is not correct. Additionally the person documenting the progress note would have been the person administering the suppository unless otherwise indicated in the note. The below information should provide further clarification related to the interventions and documentation completed." The State then reiterated IPNs that the Monitoring Team previously reviewed.

  To clarify, the State was correct, that it had not been five days between bowel movements. However, the assessment in the IPN, dated 8/4/18, at 3:48 p.m., did not include documentation to show that the nurse conduced the necessary assessment, including palpation of the abdomen, or review of fluid intake. In addition, no assessment was found in IView as the nurse had indicated in the IPN, which the State confirmed in its comments. The IPN noted that she consumed an "unknown" portion of bowel medications" and had spit some out and refused her 2 p.m. to 10 p.m. shift medications "Xs 3," but provided no indication regarding what medications these were). The IPN provided no indication that nurse notified the PCP of these refusals. The note also indicated that "PRN Biscodyl was not effective." However, there was no indication that a PRN had been administered. The IPN, dated 8/5/18, indicated that Individual #93 had not had a bowel movement since 8/1/18, and was given a suppository at 2:48 a.m. No IPN was found addressing the administration of a suppository at this time, or to show that a nurse conducted an assessment at the time it was given. There was inadequate documentation of nursing assessments and documentation of PRN medications.
- An IPN, dated 10/4/18, indicated Individual #82 fell to the floor while having a four-second seizure. The note did not indicate if the individual hit his head or face on floor (i.e., the fall was witnessed) or provide a description of an abrasion to the individual's right forearm. Also, the nurse provided no description of the individual's mental status in the IPN or IView assessment.

  In its comments on the draft report, the State disputed this finding, and stated: "Description of the abrasion was documented in the Post Injury Report dated 10/04/2018 @ 1520. **(See TX-AB-1811-II.33.d., p.32)… Per page 117 of TX-AB-1811-II.32.d**, the I-View mental status is documented."

Including a description of an injury in a post-injury report, but not in the IPNs is inconsistent with applicable standards of practice. IPNs should show assessments from the initial discovery of the injury through to resolution of the injury. This is essential for continuity of care purposes, and to allow needed analyses to occur. Similarly, the description of the individual's mental status included in the IView documentation the State referenced (i.e., "no change from baseline") was not consistent with applicable standards of care. The nurse needed to document specifics about the individual's current mental status.

- According to Document #TX.IV.1-20, on 8/2/18, Individual #187 experienced an episode of hypothermia, but no nursing assessment was found in the IPNs.
- An IPN, dated 8/26/18, at 5:59 a.m., noted that Individual #145 did not have a bowel movement during the shift. However, the note did not include when his last bowel movement was to justify the PRN medication he received later that day. The IPN, at 7:46 a.m., noted that the nurse gave the individual a suppository. However, the nurse did not conduct and/or document an assessment prior to administering it.

  The State disputed this finding, and stated: "The nurse documented the assessment in I-View on 08/26/2018 @ 0510 at the time of the administration of the PRN suppository**. (See TX-AB-1811-II.14.f., p.75).**"

  The IPN, dated 8/26/18 at 7:46 a.m., was not clear regarding what time the nurse administered the Bisacodyl. The note read: "Performed On 8/26/18 at 0746 by [name], LVN, [name]" and also indicated: "Bisacodyl Performed by [name], LVN, [name] on 8/26/18 05:10:00." The previous IPN, dated 8/26/18, at 5:49 a.m., noted no bowel movement "on this shift. 2-10 Nurse reported no recent BM." However, in this note, the nurse did not indicate that a PRN for constipation was given. Based on the documentation provided, it was not clear that the assessment in IView corresponded with the administration of the PRN medication.
- An IPN, dated 7/25/18, noted that Individual #178 fell, but did not provide any details regarding where he fell or the circumstances related to the fall. In a follow-up IPN, also dated 7/25/18, the nurse did not relevant address assessment criteria, such as mental status, changes in activity or functioning, or a pain assessment.

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

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

#	Indicator	Overall Score	Individuals: 30	93	199	82	187	145	552	178	185
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. Overall, the IHCPs for individuals reviewed did not include necessary nursing interventions. Even when IDTs included nursing assessments in IHCPs, their frequency was not sufficient to address individuals' medium and high risks.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: Many of the individuals reviewed should have had PNMT reviews or assessments, but did not. The one comprehensive assessment reviewed included some of the necessary components, but did not include a thorough review of the individual's current supports to identify where changes might be needed, and/or use data to identify the etiology of the individual's PNM issues. Without thorough reviews/assessments, comprehensive plans to address the underlying causes of the individuals' PNM issues could not be developed and implemented. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	14% 1/7	N/A	0/1	1/1	0/1	N/A	0/1	0/1	0/1	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	14% 2/7		0/1	1/1	0/1		0/1	0/1	0/1	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/2		N/A	0/1	N/A		0/1	N/A	N/A	N/A
d.	Based on the identified issue, the type/level of review/assessment	14%		0/1	1/1	0/1		0/1	0/1	0/1	0/1

	meets the needs of the individual.	2/7									
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	71% 5/7		1/1	1/1	1/1		1/1	0/1	0/1	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/7		0/1	0/1	0/1		0/1	0/1	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/5		0/1	N/A	0/1		N/A	0/1	0/1	0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2		N/A	0/1	N/A		0/1	N/A	N/A	N/A

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

- Individual #93 had a diagnosis of Parkinson's Disease, progressive neurological decline, and was experiencing the effects of poorly controlled diabetes. Due to the progressive nature of her condition, along with the multiple physical and nutritional management (PNM) issues she exhibited as detailed in the 9/4/18 ISPA (e.g., coughing, gagging, unplanned weight loss of 19 pounds in 14 months), the PNMT should have at least conducted a review. Although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined at a minimum according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. This individual's continuing decline placed her at significant risk of harm.
- Individual #199 had ongoing issues with emesis as well as weight issues, but the PNMT did not complete an assessment until she was diagnosed with aspiration pneumonia. More specifically, in the past 18 months, she had over 50 emesis. From 8/29/17 to 9/8/17, she had 12 emesis. Between December 2016, and December 2017, her weight increased by 14%. Dating back to October 2017, she was included in PNMT minutes, and according to the minutes, the PNMT completed a review, but not an assessment. On 11/3/17, Individual #199 developed aspiration pneumonia. On 11/3/17, the PNMT initiated an assessment, and on 12/18/17, completed it. While the PNMT conducted an assessment, it was significantly delayed. On 4/28/18, a diagnosis of aspiration pneumonia occurred with no evidence of an assessment or review, despite the Habilitation Therapy note, dated 9/5/18, stating that one would be completed. Again, on 11/15/18, Individual #199 developed aspiration pneumonia.
- Despite 16 falls between April 2018 and September 2018, Individual #82's IDT did not refer him to the PNMT, and the PNMT did not make a self-referral, or conduct a review. Nine of the 16 falls occurred between June 11, 2018 and September 13, 2018.

This represented a significant change in status, because according to the 2017 OT/PT update the number of falls increased from three in 2015 to 10 in 2016, and now in approximately five to six months, he fell 16 times. Additionally, his seizures reportedly had increased, which could impact other PNM-related areas. At least a review was warranted.

- Individual #145 had multiple pneumonias throughout the past year (i.e., 11/14/17, 12/12/17, 3/19/18, 8/4/18, 8/28/18, and 9/14/18). There was no evidence that the IDT made a formal referral, and although PNMT minutes stated the issue, the PNMT conducted no formal review or assessment. Due to the ongoing nature of the pneumonia, which negatively impacted the individual's lungs, a PNMT referral and assessment was warranted.
- On 10/3/17, when Individual #552 had a fever secondary to an ileus, and returned from hospital after an emesis event on 1/12/18, in which fecal material was found, his IDT did not make a referral to the PNMT, and the PNMT did not conduct at least a review. The reason the PNMT gave for not reviewing the fever was that the ileus was noted to be medical in nature. Given the resulting fever as well as the PNMT minutes showing that on 1/18/18, Individual #552 met the threshold for referral and review, it was not clear why they did not conduct one. PNMT minutes for January, February, and March 2018 only stated that the individual had a small bowel obstruction.
- Individual #178's IDT did not make a referral to the PNMT despite 12 falls since April 2018. Six of these falls occurred after 7/23/18, when the IDT held an ISPA meeting to discuss falls. At the ISPA meeting on 7/23/18, the IDT did not develop an action plan that addressed the etiology of his falls, and after the meeting, the IDT did not conduct follow-up. For example, the OT stated that the PT would be consulted, but there was no evidence of this being done. As stated above, although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined <u>at a minimum</u> according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. This individual's continuing falls placed him at significant risk of harm.
- Individual #185 had a history of aspiration pneumonia (i.e., 2/25/17, and 12/12/17), but his IDT did not make a referral, and the PNMT did not provide a review. PNMT minutes, dated 12/17/17, stated that the individual returned from the hospital, and the PNMT discussed him, but he did not meet criteria. However, given his history, the PNMT minutes did not document the specific discussion or rationale for the PNMT not conducting at least a review. Such discussion also was not found in IPNs, or ISPAs.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments. In its comments on the draft report, the State disputed this finding, and stated: "Upon the statewide change to IRIS Electronic Health Records, there were no more dual systems for documenting participants for the PNMT Assessments. Paper sign-in sheets became obsolete as all the PNMT members that participated in the PNMT Assessment are listed in the form browser PNMT Assessment form on the last page. For example, **see TX-AB-1811-II.10.c, p. 18 of 18** (PNMT Assessment Participants page from IRIS)." Given that PNMT members are licensed clinicians, the Center needs to have a mechanism in place to verify the participation of each clinician in the PNMT assessment process. The author or person entering information could potentially populate the list of participants that the State references without those participants having any role in the process or even knowing that they are listed as participants. Other entries in IRIS provide a "signature" of sorts, because the system identifies the author of each entry as the user that entered the system using a password. Such entries are also time-stamped. Given the ongoing challenges with IRIS related to the inability to have more than one user "sign" a document, the State should propose a mechanism to allow this verification (i.e., allowing one user to simply include the names of "team members" at the bottom of the report

does not suffice).

e. It was positive that with a couple of exceptions that an RN Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. The exceptions were:

- No evidence was found of a PNMT RN assessment after Individual #178's hospitalizations on 5/3/18, for vomiting and small bowel obstruction.
- For Individual #552, the PNMT RN did not conduct a review for his hospitalization on 10/3/17.

h. As noted above, Individual #145 should have had a comprehensive PNMT assessment, but did not. The following provide examples of findings for the PNMT assessment reviewed:

- Individual #199's assessment lacked evidence of face-to-face observations. The PNMT did not complete a review of all relevant supports. For example, her type of mobility was listed, but the PNMT did not document a review of whether or not this level of ambulation was sufficient to assist with weight loss, gastric emptying, and/or lung clearance. Using a data-based approach, the PNMT did not identify the underlying cause(s) of her PNM issues. On a positive note, the PNMT described the presenting problem; discussed pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs; reviewed the applicable risk ratings, with analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification; and discussed medications that might be pertinent to the problem, and discussed their relevance to PNM supports and services.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Some improvement was noted with regard to the inclusion in IHCPs of PNM triggers, as well as definition of monitoring/review of progress. Overall, though, more work was needed to ensure that ISPs/IHCPs comprehensively set forth plans to address individuals' PNM needs. In addition, regression was noted with regard to the quality of PNMPs. Staff should focus on clearly connecting triggers to the risk areas to which they apply. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	22% 4/18	0/2	0/2	1/2	0/2	0/2	1/2	0/2	2/2	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.	78% 14/18	0/2	1/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	56% 10/18	0/2	0/2	1/2	1/2	2/2	1/2	1/2	2/2	2/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	61% 11/18	1/2	1/2	2/2	0/2	2/2	2/2	1/2	1/2	1/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #30 - choking, and falls; Individual #93 – choking, and weight; Individual #199 – aspiration, and GI problems; Individual #82 – choking, and falls; Individual #187 – aspiration, and choking; Individual #145 – skin integrity, and aspiration; Individual #552 – choking, and GI problems; Individual #178 – choking, and falls; and Individual #185 – GI problems, and aspiration.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP.

b. The IHCPs that included preventative PNM interventions to minimize the individuals' risks were those for: Individual #199 – GI problems; Individual #187 – aspiration, and choking; Individual #145 – aspiration; and Individual #178 – choking, and falls.

c. It was concerning to see a significant drop in scores for PNMPs. All individuals reviewed had PNMPs and/or Dining Plans, which were reviewed and/or updated within the last 12 months.

- It was positive that all of the PNMPs, as applicable to the individuals' needs included:
  - Descriptions of assistive/adaptive equipment;
  - Positioning instructions;
  - Transfer instructions;
  - Mobility instructions;
  - Toileting/personal care instructions;
  - Handling precautions or moving instructions;
  - Mealtime instructions;
  - Medication administration instructions;
  - Oral hygiene instructions: and
  - Complete communication strategies.
- As applicable to the individuals, most, but not all of the PNMPs reviewed:
  - Two PNMPs were missing some pictures. The State disputed this finding, and stated: "All requested and submitted PNMPs for the document request for the named individuals in this indicator had the required photos." To clarify the finding, the PNMPs that did not include the necessary pictures were for Individual #82 (i.e., using his rolling walker, which might lead staff to assume that he only uses his wheelchair), and Individual #187 (i.e., with his gait belt).

- The component of the PNMPs on which the Center should focus on making improvements includes:
  - The triggers included in PNMPs/Dining Plans were not connected to specific PNM concerns, so it would be difficult for direct support professionals to determine when a trigger was alerting them to a problem with a specific risk.

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

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #93 – choking; Individual #199 – aspiration, and GI problems; Individual #82 – falls; Individual #187 – aspiration, and choking; Individual #145 – skin integrity, and aspiration; Individual #552 – choking, and GI problems; Individual #178 – choking, and falls; and Individual #185 – GI problems, and aspiration.

f. The IHCPs that identified triggers and actions to take should they occur were those for: Individual #199 – GI problems; Individual #82 – choking; Individual #187 – aspiration, and choking; Individual #145 – skin integrity; Individual #552 – GI problems; Individual #178 – choking, and falls; and Individual #185 – GI problems, and aspiration.

g. The IHCPs that defined the frequency of monitoring/review of progress were for: Individual #30 – choking; Individual #93 – choking; Individual #199 – aspiration, and GI problems; Individual #187 – aspiration, and choking; Individual #145 – skin integrity, and aspiration; Individual #552 – choking; Individual #178 – choking; and Individual #185 – GI problems.

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	30	93	199	82	187	145	552	178	185
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	67% 2/3	N/A	0/1	N/A	N/A	N/A	1/1	N/A	N/A	1/1
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				N/A			N/A
Comments: a. and b. For two of the three individuals with enteral nutrition, IDTs provided justification for their continued use in the IRRFs. Based on staff report, Individual #93 was eating all meals and taking all medications by mouth so her need for a G-tube was unclear. Her IRRF should have, but did not provide information or data regarding use of the G-tube tube and why it was still needed.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: A significant issue was that Center staff had not followed the current guidelines for considering when an OT/PT comprehensive assessment should be repeated. For a number of individuals reviewed, the three-year mark had passed, and OTs/PTs had not completed a new comprehensive assessment, or provided individualized clinical justification for why an update met the individual's needs. In a number of cases, OTs/PTs concluded that the individual's status was accurately reflected in the three- to four-year-old assessment, despite considerable evidence to the contrary. In addition, the assessments reviewed needed considerable improvement. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	33% 3/9	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	44% 4/9	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of:	N/A									

	▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	0/1	0/1	N/A	N/A	0/1	0/1	N/A	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/4	N/A	N/A	0/1	0/1	N/A	N/A	0/1	N/A	0/1

Comments: a. and b. The following provide examples of concerns noted:

- Individual #30's last comprehensive OT/PT assessment was completed in 2013. The OT/PT Update, dated 5/11/18, stated: "most recent comprehensive OT/PT evaluation is dated 6/11/2013 and remains a current representation of his/her functional ability and fine motor skill." This generic statement was not individualized to reflect the specific clinical justification for not completing a new comprehensive assessment. In addition, it was inaccurate, in that the 2013 assessment was not a current representation of her status. Specifically, Individual #30 had a decline in ambulation and/or stability as evidenced by 10 falls in the past 11 months. The OT/PT had provided no consultations, and the IDT had not held an ISPA meeting to address these falls, which dated back to September 2017. The OT/PT should have completed a new comprehensive assessment, but did not.
- In 2013, an OT/PT completed Individual #187's last comprehensive assessment. Despite the fact that he experienced a significant decline in that he went from not using a wheelchair to using a wheelchair as his primary method of mobility, the OT/PT did not complete a comprehensive assessment in 2018 (i.e., the OT/PT recognized the decline, but completed an update anyways).
- In 2012, Individual #178's last comprehensive assessment was completed. Since that time, he experienced multiple declines. In addition, since April 2018, he fell 12 times, but the OT/PT had not completed a consultation.
- Similarly, the following individuals' last comprehensive OT/PT assessments were completed at least three years ago: Individual #93, and Individual #145. Sufficient justification was not provided for not completing another comprehensive assessment. As a result, individuals did not have timely assessments and assessments that met their needs.
- In Individual #185's update, dated 4/18/18, the PT recommended a HOBE evaluation. Based on the documents submitted, it was not completed.

d. As discussed above, Individual #30, Individual #93, Individual #187, Individual #145, and Individual #178 should have had comprehensive assessments, but did not.

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

- The individual's preferences and strengths are used in the development of OT/PT supports and services; 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).

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

- 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; and
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports.

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.	
Summary: IDTs need to include in ISPs concise, but thorough descriptions of individuals' OT/PT functional statuses. Given that over the last two review periods and during this review, the IDTs of individuals reviewed approved PNMPs/positioning schedules as part of the ISP process, including providing a brief summary of any changes made/needed (Round 12 – 100%, Round 13 – 100%, and Round 14 - 100%), Indicator b will move to the category requiring less oversight. IDTs also included OT/PT interventions, strategies, and programs in individuals' ISPs, but due to problems with assessments, IDTs did not have comprehensive sets of recommendations to consider. When changes to these interventions and programs are needed during the ISP year, IDTs need to meet and document the	Individuals:

decisions made. The remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	25% 1/4	N/A	1/1	N/A	0/1	0/1	N/A	N/A	N/A	0/1

Comments: a. The ISPs reviewed did not include concise, but thorough descriptions of individuals' OT/PT functional statuses. Therapists should work with QIDPs to make improvements.

b. It was good to see that the IDTs of individuals reviewed approved PNMPs/positioning schedules as part of the ISP process, including providing a brief summary of any changes.

c. IDTs of individuals reviewed also did a good job of including in annual ISPs the OT/PT strategies, and interventions, and programs recommended in assessments. However, due to the lack of thorough assessments, and complete sets of recommendations to address individuals' OT/PT needs, this was a false positive.

d. Based on documents submitted, examples of concerns included:

- Individual #82's IDT did not hold an ISPA meeting to discuss and approve initiation of direct PT treatment.
- Individual #187's IDT did not meet to discuss revisions to his SAP (i.e., from using his arms to move his wheelchair to using his lower extremities for this purpose).
- Individual #185's IDT did not hold an ISPA meeting to discuss findings from the sensory assessment, dated 9/25/18.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: For a number of individuals reviewed, the three-year mark had passed, and SLPs had not completed a new comprehensive assessment, or provided	Individuals:

individualized clinical justification for why an update met the individual's needs. Significant work is needed to improve the quality of communication assessments in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.											
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	67% 6/9	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	67% 6/9	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication;	N/A									

	• Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	N/A	0/1	N/A	0/1	N/A	0/1	N/A	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/6	0/1	N/A	0/1	N/A	0/1	N/A	0/1	0/1	0/1

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

- In 2014, a Speech Language Pathologist (SLP) completed Individual #93's last comprehensive communication assessment. Since then, updates indicated that her use of sign language devolved. However, an SLP had not completed a thorough assessment regarding, for example, the potential use of high tech AAC. Another comprehensive assessment was warranted, but not completed
- In 2013, Individual #82's last comprehensive assessment was completed. Given that he never received a proper assessment of AAC possibilities, a comprehensive assessment was warranted. In the past, this portion of the assessment involved single-opportunity trials, which did not provide intense enough exposure to identify AAC devices that might meet his needs.
- At the time of Individual #145's last comprehensive assessment in 2013, he was able to reach out to devices, but his 2018 update indicated he no longer had this skill. Another comprehensive assessment was warranted to determine if declines had occurred in other areas, and to revisit his potential for the use of AAC/EC devices.

d. As discussed above, Individual #93, Individual #82, and Individual #145 should have had comprehensive assessments, but did not.

e. Considerable work was needed to improve the quality of the communication assessments. However, it was positive that the nine updates reviewed (i.e., to provide feedback on the updates, the Monitoring Team reviewed all nine that the Center submitted) met criteria, as applicable, with regard to:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication.

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

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

- The individual's preferences and strengths are used in the development of communication supports and services;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and

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

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: In the ISPs for the nine individuals, IDTs reviewed, approved, and summarized their discussion about Communication Dictionaries. IDTs also included communication interventions, strategies, and programs in individuals' ISPs, but due to problems with assessments, IDTs did not have comprehensive sets of recommendations to consider. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: b. It was good to see that the IDTs of individuals reviewed approved Communication Dictionaries as part of the ISP process, including providing a brief summary of any changes. c. IDTs of individuals reviewed also did a good job of including in annual ISPs the communication strategies, and interventions, and programs recommended in assessments. However, due to the lack of thorough assessments, and complete sets of recommendations to address individuals' communication needs, this was a false positive.											

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: There was improvement in performance for all three indicators. It was very good to see that so many of the SAPs had reliable data. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 30	557	437	479	93	526	231	537	549
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.	68% 17/25	2/2	0/3	2/3	1/2	2/3	3/3	1/3	3/3	3/3
4	SAPs are practical, functional, and meaningful.	40% 10/25	2/2	0/3	1/3	0/2	1/3	2/3	0/3	2/3	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	84% 21/25	1/2	3/3	2/3	1/2	3/3	3/3	3/3	3/3	2/3

Comments:
All of the nine individuals reviewed by the behavioral health monitoring team had Skill Acquisition Plans (SAPs). Three SAPs were reviewed for seven of these individuals. The exceptions were Individual #30 and Individual #479 who each had two SAPs.

3. Seventeen of the 25 SAPs were based on either the Functional Skills Assessment (FSA) or the current level of performance reported in the SAP. Exceptions included skills that had been identified as mastered (Individual #557 - clean room, Individual #231 - job application), mastered skills with which the individual was noncompliant (Individual #557 - apply deodorant, Individual #437 - daily schedule), or skills that were not assessed specifically or with needed materials (Individual #557 - draw conclusion; Individual #479 - sign, Individual #93 - express feelings, Individual #231 - emergency information).

4. Ten of the 25 SAPs were considered to be practical, functional, or meaningful. For the other 15, in addition to those skills that were identified as mastered and those that addressed compliance, exceptions included the following:

a) SAPs that did not include the use of meaningful or adapted materials (e.g., Individual #557 was reading simple passages and providing one word answers to questions that were repeated over time, Individual #437 could learn to use a name stamp to sign his name rather than spending time learning to print his name, Individual #479 was going to learn to use an augmentative speech device, but this was not yet available, and Individual #549 could learn to send cards to her family by using a name stamp to sign the card, using a jig to address an envelope, and traveling to the post office to mail the card).
b) SAPs that did not teach meaningful skills (e.g., Individual #526 could learn appropriate ways to greet people - as written he is to approach others with his arm raised before extending his arm to identify appropriate space, Individual #231 should learn information she would provide during an emergency off campus, Individual #231 can identify healthy versus unhealthy foods -

it would be advisable to work with an expert to address her eating issues related to her diagnosis of Prader Willi rather than focusing on verbal report, and Individual #537 requires staff assistance to take a shower - teaching him to transition to the bathroom at the sound of an alarm will not increase his independence particularly as the time he takes a shower is likely determined by staff).

c) SAPs that did not address the identified goal (e.g., Individual #231 was to earn $100 per month, but the SAP addressed her completing a job application).

5. Twenty-one of the 25 SAPs had been monitored for data reliability in the past six months. The exceptions were the following SAPs: Individual #30 - apply lotion, Individual #437 - print name, Individual #479 - pedestrian safety, and Individual #549 - letter.

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: Performance remained within about the same range when looking at this and the last two reviews. Some additional attention to the details of the requirements of these assessment-related indicators should move them into higher performance scores. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 30	557	437	479	93	526	231	537	549
10	The individual has a current FSA, PSI, and vocational assessment.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	44% 4/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1
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:

10. Seven of the nine individuals had current Functional Skills Assessments, Preferences and Strengths Inventories, and vocational assessments. Vocational assessments were not provided for Individual #231 and Individual #537.

Note that Individual #557 also did not have a vocational assessment, however, he was 15 years old at the time of his ISP meeting. At his next annual ISP, a vocational assessment is warranted to begin planning for his transition from school to adult life. When asked, Individual #557 indicated he might want to be a mechanic. This is a job skill that should be assessed for interests and abilities, particularly as he could be introduced to this work during his summer vacation.

11. As noted in the QIDP tracking data, assessments that were completed were available by the identified due data for four of the nine individuals (Individual #479, Individual #93, Individual #537, Individual #549). The FSA was late for Individual #30, Individual #557, Individual #437, Individual #526, and Individual #231. Additionally, Individual #437's vocational assessment was late.

12. The assessments for seven of the nine individuals included SAP recommendations. (As there was no vocational assessment for Individual #557, Individual #231, or Individual #537, SAP recommendations were not scored in this area.) The two exceptions were Individual #437 and Individual #549 whose vocational assessments did not include SAP recommendations.

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 clinical services, and implementation of plans by the various clinical disciplines. Thirty of these were moved to, or were already in, the category of requiring less oversight after the last review. Presently, nine additional indicators will move to the category requiring less oversight. These were in the areas of restraints, psychiatry, psychology, medical, pharmacy, and dental. This includes the entirety of Outcome #1 for psychiatry, and Outcome #5 for psychology.

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 psychiatry, previously missing components of the quarterly review documentation content were now corrected/included.

In behavioral health, without data that are trusted and reliable, a true determination of progress cannot be made. Even so, based on the data that were available, two of the individuals were making progress. Seven individuals were not making progress, and modifications were made to the programs of about half. These modifications were implemented, which was an improvement since the last review.

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

Acute Illnesses/Occurrences

When there were more than three crisis intervention restraints within a 30-day period, it was good to see that all aspects of the required review were done following the restraint occurrences.

In psychiatry, despite the lack of reliable data regarding psychiatric indicators, it was evident that the psychiatry department intervened when an individual's psychiatric status was deteriorating. The related documentation appeared in the IPNs and the notes of interim psychiatric clinics.

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

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

During regular business hours, the PCP or assigned covering PCP should attempt to evaluate and stabilize individuals for whom emergency/911 care is needed, but this did not appear to be a consistent practice at the Center. The Center also should ensure that when individuals return from hospitalizations, IDTs hold ISPA meetings and address follow-up medical and healthcare supports to reduce risks and promote early recognition, as appropriate. It was good to see that PCPs conducted necessary follow-up for the acute issues reviewed.

Based on the one dental emergency reviewed, the dentist provided the individual with timely dental assessment and care, including pain management. Based on the Center's sustained performance, all three indicators in Outcome #7 for dental will move to the category requiring less oversight.

Implementation of Plans

The psychiatry department continued to meet the required timeline and content guidelines for the psychiatric treatment plans and the quarterly psychiatric clinics.

In psychiatry, criteria for side-effect assessment were met for most individuals.

In data collection systems for PBSPs, when looking across this set of five indicators, there was improvement compared with the previous two reviews.

The PBSP graphs at Abilene SSLC were not clear and understandable. Important information was not included and some were incorrectly labeled. On the positive, the Center returned to high performance regarding follow-up to peer review recommendations.

There was evidence that more than 80% of the staff assigned to work with almost all individuals had been trained on the individuals' PBSPs. Vocational and activity center staff had also received training.

For many of the individuals' PBSPs, there was evidence that revisions were made throughout the year following recommendations from the IDT or internal/external peer review.

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.

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

It was positive that over the last two review periods and during this review, for the non-Facility consultations reviewed, the PCPs wrote IPNs that explained the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there was a need for referral to the IDT. This resulted in the related indicator moving to the category requiring less oversight. During this review, the Center also showed progress with regard to providers completing timely reviews of consultation reports.

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.

Five of the nine individuals reviewed were edentulous. The two individuals reviewed with medium or high dental caries risk received fluoride applications twice per year.

Considerable work is needed to ensure that individuals' ISPs define the suction tooth brushing that they need, the suction tooth brushing occurs as planned, and Dental Department staff conduct monitoring at a frequency that IDTs determine.

Overall, Quarterly Drug Regimen Reviews (QDRRs) addressed many of the necessary components. The components needing continued focus were lab results, and the risk of metabolic syndrome due to the use of new generation antipsychotics. Over this review and the previous two reviews, practitioners generally implemented agreed-upon recommendations from QDRRs, and as a result, the related indicator will move to the category requiring less oversight.

For most individuals the Monitoring Team observed, their adaptive equipment fit properly.

Overall, PNMP/Dining Plan implementation at Abilene SSLC showed improvement (i.e., Round 11 – 33%, Round 12 – 31%, Round 13 – 38%, and now, Round 14 – 61%). While this is movement in the right direction, efforts are still needed to continue to improve Dining Plan implementation, and positioning. Often, the errors that occurred (e.g., eating at an unsafe rate, missing equipment designed to prevent skin breakdown) placed individuals at significant risk of harm. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill

Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

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: One occurrence was reviewed by the Monitoring Team. It was for an incident with four consecutive crisis intervention restraints, something not typical for the individual. It was good to see that all aspects of the required review were done following the restraint occurrences. Given sustained high performance over three consecutive reviews, indicator 27 will be moved to the category of requiring less oversight. The same might occur for other indicators after the next review if sustained high performance occurs. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	530								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 1/1	1/1								
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 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.	100% 1/1	1/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 1/1	1/1								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the	100% 1/1	1/1								

	behaviors that provoke restraint, a plan to address them?										
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	100% 1/1	1/1								
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% 1/1	1/1								
26	The PBSP was complete.	0% 0/1	0/1								
27	The crisis intervention plan was complete.	100% 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% 1/1	1/1								
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

18-23. Individual #530 was placed in restraint four times during one crisis episode. Staff reported that he became upset when an individual from another home entered his home and broke a toilet lid. Individual #530 was trying to obtain broken pieces and staff implemented repeated holds to protect him.

The IDT met within 10 business days and reviewed adaptive skills, biological/medical/psychosocial issues, environmental variables, environmental antecedents, and consequences.

This was an unusual situation that was being addressed with the other individual.

24-25. Individual #530 had a current PBSP and CIP at the time of repeated restraint.

26. The PBSP was not considered complete. The replacement behaviors were not functionally equivalent. Further, although there were

operational definitions of targeted problem behaviors, three of four of these (disruptive behavior, aggression, and self-injury) were measured as episodes that were separated by 15 minutes without the occurrence of the identified behavior. Graphs depicting the rate of these behaviors were labeled frequency. This measurement system can result in underreporting of these behaviors.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: Given the long-standing correct implementation of Reiss scales, the Monitor will move indicator 3 into the category of requiring less oversight, too.			Individuals:									
#	Indicator	Overall Score										
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, 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.	N/A										
Comments: 3. All of the individuals who were not followed by psychiatry had Reiss scores that were below the clinical cutoff.												

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.												
Summary: Once Abilene SSLC routinely obtains reliable data for psychiatric indicators, then indicators 8 and 9 can be assessed by the Monitoring Team. Similarly, indicators 10 and 11 can then be assessed, too. That being said, the Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
8	The individual is making progress and/or maintaining stability.	0% 0/8	0/2	0/2		0/2	0/2	0/2	0/2	0/2	0/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1

Comments:
8. Although the Center had made progress in developing psychiatric indicators and goals to increase and decrease, they did not appear in an IHCP. In addition, a careful review of the integrity of the behavioral data performed by the Monitoring Team indicated that the data were not reliable. Thus, it would not be possible to determine if progress was being made on goals for reduction or increase.

9. The deficits described above also made it impossible to determine if goals for behaviors to increase or decrease needed to be updated or modified.

10. Despite the lack of reliable data, it was evident that the psychiatry department intervened when an individual's psychiatric status was deteriorating. The related documentation appeared in the IPNs and the notes of interim psychiatric clinics. The psychiatric providers routinely reviewed each individual who has a medication change in the following month rather than waiting to the next quarterly review.

11. The interventions and revisions to treatment that are ordered were routinely implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: As found during previous reviews, about one-quarter of the PBSPs did not show psychiatry participation. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
24	The psychiatrist participated in the development of the PBSP.	75% 6/8	0/1	1/1		1/1	0/1	1/1	1/1	1/1	1/1

Comments:
24. The documentation of the psychiatrist's participation in the development of the behavioral plan appeared in documents entitled "Case Formulation Discussion," which were dated and signed by both the psychiatric provider and the behavioral health specialist. This documentation was present for all of the individuals, except Individual #30 and Individual #93.

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:			Individuals:								
#	Indicator	Overall Score									
25	There is evidence of collaboration between psychiatry and neurology	Due to the Center's sustained performance, these indicators were moved to the									

	for individuals receiving medication for dual use.	category of requiring less oversight.
26	Frequency was at least annual.	
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	
Comments:		

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

Summary: Previously missing components of the quarterly review documentation content were now corrected/included, leading to 100% scoring for indicator 34. This indicator will remain in active monitoring. Also, see comment below regarding one of the psychiatry clinics.

#	Indicator	Overall Score	Individuals: 30	557	437	479	93	526	231	537	549
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.	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
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:

34. The documentation in the quarterly reviews was thorough and contained the required content.

35. The psychiatric clinics for Individual #557, Individual #479, Individual #537, and Individual #549 were observed by the Monitoring Team during the week of the onsite review. The required team members were present and participated in the meetings. The behavioral data were presented through the prior week for all of these individuals, except Individual #479. The BHS presented the data though the end of the prior month and when the psychiatric provider inquired about the most recent data (for November 2018), it was reported that this information was not available.

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

Summary: This indicator will remain in active monitoring. Criteria were met for most individuals.

#	Indicator	Overall Score	Individuals: 30	557	437	479	93	526	231	537	549
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	88% 7/8	1/1	1/1		1/1	1/1	1/1	1/1	0/1	1/1

Comments:

36. The AIMS and MOSES evaluations were completed in a timely manner for the eight individuals for whom they were necessary. Individual #437 was not prescribed psychotropic medications and, thus, did not require these side effect assessments.

The 7/16/18 AIMS and MOSES for Individual #537 were not reviewed by the prescriber until 8/26/18, but the others were all reviewed within the required time frame.

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

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These indicators remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A									
Comments:											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.												
Summary:			Individuals:									
#	Indicator	Overall Score										
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.											
Comments:												

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: Without data that are trusted and reliable, a true determination of progress cannot be determined (indicator 6). Even so, based on the data that were available, two of the individuals were making progress. Seven individuals were not making progress, and modifications were made to the programs of about half. These modifications, however, were implemented, which was an improvement since the last review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A									
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	57% 4/7	1/1		0/1	0/1	0/1	1/1	1/1	1/1	
9	Activity and/or revisions to treatment were implemented.	100% 4/4	1/1					1/1	1/1	1/1	
Comments:											

6. Seven of the nine individuals (Individual #30, Individual #437, Individual #479, Individual #93, Individual #526, Individual #231, Individual #537) were not making progress on their PBSP goals according to the Center's data. Although the Center's data suggested progress for Individual #557 and Individual #549, all nine individuals were rated zero on this indicator due to the identified problems with data timeliness and inter-observer agreement (indicator 5).

7. None of the individuals had met their PBSP goals.

8-9. Even so, there was evidence that corrective actions had been identified and added to the PBSP for four of the seven individuals who were not making progress. These were Individual #30, Individual #526, Individual #231, and Individual #537.

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

Summary: Abilene SSLC attended to staff training of PBSPs. This has been the case for this review and the previous three reviews too with some exceptions in May 2017. Any exceptions during this and the previous review showed that most staff were trained, but slightly below the 80% requirement. Therefore, indicator 16 will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
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.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.										

Comments:

16. A comparison was made between a list of staff assigned to work with the individual and training rosters. This comparison revealed that 80% or more of assigned staff had been trained on the PBSP for eight of the nine individuals. The exception was Individual #479 for whom many staff were trained, but not 80% or more. Training rosters also included the names of staff assigned to work in the individual's various day program sites (e.g., work, recreational, activity center).

18. During the onsite visit, the assigned BCBA was often observed in the homes for Individual #537, Individual #93, and Individual #231. It was positive to see such frequent interaction with the individuals whom they support.

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

Summary: Clear, understandable graphic presentations are a hallmark of applied behavior analytic supports. The PBSP graphs at Abilene SSLC were not clear and understandable. Important information was not included and some were

Individuals:

incorrectly labeled. This is particularly important because those data graphs are then used by treating clinicians at various reviews (e.g., indicators 21 and 22). On the positive, the Center returned to high performance on indicator 22 regarding follow-up to peer review recommendations. Therefore, indicator 22 will be returned to the category of requiring less oversight.

#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	75% 3/4		1/1		0/1				1/1	1/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 6/6	1/1			1/1		1/1	1/1	1/1	1/1
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

20. Although graphs were included for all nine individuals, only the ones for Individual #231 were considered useful for making data-based treatment decisions.

- For five of the remaining eight individuals, phase change lines were not consistently included to note the introduction of a new/revised PBSP, changes to a token economy, changes in operational definitions, introduction of a new device for measuring blood sugar levels, introduction of a sensory diet, changes in thyroid medication, changes in work schedule, etc.
- For seven individuals (Individual #30, Individual #437, Individual #479, Individual #93, Individual #526, Individual #537, Individual #549), some graphs were labeled as frequency measures when, in fact, the behavior was measured in episodes, separated by a period of time without the behavior. The term frequency can be very misleading because multiple occurrences of the behavior can occur within one episode.

21. During the onsite visit, observations were conducted of the psychiatric clinic for four individuals. At the meetings for Individual #557 and Individual #537, the BCBA presented data on PBSP target behavior through 11/11/18. Following a prompt from the psychiatric nurse, the BCBA reported on Individual #549's PBSP target behavior through this same date after accessing this information on her computer. The exception was at the meeting for Individual #479. The BHS staff member reported data for October 2018 after the psychiatrist requested this information. He was unable to report on November 2018 data.

22. Six of the nine individuals (Individual #30, Individual #479, Individual #526, Individual #231, Individual #537, Individual #549) were reviewed by the Internal and/or External Peer Review Committees during a six-month period. In every case, there was evidence that at least some of the recommendations had been included in the individual's revised PBSP.

Outcome 8 – Data are collected correctly and reliably.

Summary: When looking across this set of five indicators, there was improvement compared with the previous two reviews. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 30	557	437	479	93	526	231	537	549
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

26. The data collection system for measuring target behaviors was determined to be adequate for Individual #557.

For seven of the remaining eight individuals (Individual #30, Individual #437, Individual #479, Individual #93, Individual #526, Individual #537, Individual #549), at least one of their targeted problem behaviors was measured as an episode. Episodes were separated by the passage of two to 10 minutes of time without the occurrence of the targeted response. This can result in under-reporting of the problem behavior. Staff are advised to consider measuring the duration of episodes or converting to a partial interval recording system using relatively short (e.g., five minutes) periods of time.

For both Individual #437 and Individual #231, the definition of disruptive behavior included a range of behaviors. Concerns with this grouping of very different behaviors, sometimes with different consequences, were addressed earlier in this report.

27. For eight of the nine individuals, the data collection system described in the PBSP adequately measured his or her replacement behavior(s). The exception was Individual #479. His PBSP did not include directions for recording data on his replacement behavior.

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

29. Monitoring of data timeliness was occurring monthly for all nine individuals. Monthly or more frequent monitoring of IOA and treatment integrity was expected for six individuals: Individual #557, Individual #479, Individual #526, Individual #231, Individual #537, and Individual #549. (Because Individual #537's PBSP indicated that this monitoring would occur bi-monthly, staff are advised to clarify whether this means twice each month or every other month).

For Individual #30, Individual #437, and Individual #93, IOA and treatment integrity were to be monitored quarterly. Because none of these individuals were making expected progress, more frequent monitoring should be considered.

30. As indicated earlier in this report, the Center had begun assessing data timeliness. While the reports showed improvement over a six-month period, goal levels were achieved for Individual #437 and Individual #549. IOA measures were regularly assessed at goal levels for Individual #30, Individual #557, and Individual #479.

Lastly, treatment integrity measures were regularly assessed at goal levels for Individual #479 and Individual #526.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 30	93	199	82	187	145	552	178	185
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.	6% 1/18	0/2	0/2	1/2	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 #30 – diabetes, and cardiac disease; Individual #93 – diabetes, and other: palliative care; Individual #199 – GI problems, and weight; Individual #82 – falls, and seizures; Individual #187 – cardiac disease, and other: hospice care; Individual #145 – respiratory compromise, and GI problems; Individual #552 – constipation/bowel obstruction, and weight; Individual #178 – falls, and UTIs; and

Individual #185 – respiratory compromise, and infections).

None of the goals/objectives reviewed were clinically relevant, achievable, and measurable. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #199 – weight.

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

Outcome 4 – Individuals receive preventative care.

Summary: Nine of the nine individuals reviewed received the preventative care they needed, which was very good to see. Given the importance of preventative care to individuals' health, these indicators will continue in active oversight 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. 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	30	93	199	82	187	145	552	178	185
a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 4/4	1/1	N/A	1/1	N/A	N/A	1/1	N/A	1/1	N/A
	iii. Breast cancer screening	100% 2/2	1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
	iv. Vision screen	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	vi. Osteoporosis	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	N/A									
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments: a. The individuals reviewed received timely preventive care, which was good to see.

b. Individual #145's PCP analyzed the QDRR findings, and developed a plan to address them.

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

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

Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
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	N/A	N/A	0/1	N/A	N/A	N/A	N/A

Comments: a. Since 8/24/09, Individual #187 has had a DNR Order in place. Since 2/25/15, he has been on hospice. Review of hospice notes for the past three months showed stability and not a decline. Based on discussion with the State Office Discipline Lead, this individual did not meet State Office criteria for a DNR that Center staff would implement, although he would likely not benefit from full code status. The Monitoring Team recommends that Center staff work with State Office to review applicable policy to determine how to proceed based on this individual's prognosis.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

Summary: During regular business hours, the PCP or assigned covering PCP should attempt to evaluate and stabilize individuals for whom emergency/911 care is needed, but this did not appear to be a consistent practice at the Center. It was good to see that PCPs conducted necessary follow-up for the acute issues reviewed.	Individuals:

Given that over the last two review periods and during this review, when an individual reviewed transferred to the hospital or ED, the PCP or a nurse generally communicated necessary clinical information with hospital staff (Round 12 – 86%, Round 13 – 100%, and Round 14 - 100%), Indicator f will move to the category requiring less oversight. The remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
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.	73% 8/11	2/2	N/A	2/2	N/A	N/A	1/2	1/1	1/2	1/2
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.	100% 9/9	2/2		1/1			2/2	1/1	2/2	1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	80% 9/10	1/1	1/1	2/2	1/1	N/A	1/2	1/1	2/2	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	75% 6/8	0/1	N/A	2/2	N/A		1/2	1/1	2/2	
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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 8/8	1/1	1/1	N/A	1/1		2/2	1/1	2/2	
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	67% 2/3	N/A	0/1	N/A	N/A		2/2	N/A	N/A	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem	100% 7/7	1/1	1/1	2/2	1/1		2/2	N/A	N/A	

	with documentation of resolution of acute illness.										

Comments: a. For six of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses addressed at the Center, including: Individual #30 (right scalp lesion on 9/2/18, and bruised toes on 7/11/18), Individual #199 (hand trauma on 9/17/18, and memory loss and confusion on 7/26/18), Individual #145 (allergies on 8/14/18, and cyanosis on 10/3/18), Individual #552 (weight loss and abdominal mass on 5/1/18), Individual #178 (paleness and tiredness on 5/24/18, and left ear drainage on 5/29/18), and Individual #185 [dental pain on 9/17/18, and gastrostomy-tube (G-tube) dermatitis on 4/2/18].

Except for the following for which the source(s) for information was not documented or a definitive or differential diagnosis that clinically fit the corresponding evaluation or assessment(s) was not provided, PCPs assessed the acute issues reviewed according to accepted clinical practice: Individual #145 (cyanosis on 10/3/18), Individual #178 (paleness and tiredness on 5/24/18), and Individual #185 (dental pain on 9/17/18).

b. It was good to see that for the acute illnesses reviewed that were treated at the Center, the PCPs 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.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #30 (ED visit for new onset seizure with laceration on 4/30/18), Individual #93 (hospitalization for sepsis, hypotension, and fever on 4/15/18), Individual #199 (Infirmary admission for emesis on 9/19/18, and Infirmary admission for emesis on 10/2/18), Individual #82 (ED visit for status epilepticus on 4/6/18), Individual #145 (hospitalization for pneumonia on 8/30/18, and hospitalization for pneumonia on 9/14/18), Individual #552 (hospitalization for shortness of breath on 5/3/18), and Individual #178 (ED visit for abdominal pain on 5/29/18, and ED visit for abdominal pain on 5/30/18).

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

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #199 (Infirmary admission for emesis on 9/19/18, and Infirmary admission for emesis on 10/2/18), Individual #82 (ED visit for status epilepticus on 4/6/18), Individual #145 (hospitalization for pneumonia on 8/30/18), Individual #552 (hospitalization for shortness of breath on 5/3/18), and Individual #178 (ED visit for abdominal pain on 5/29/18, and ED visit for abdominal pain on 5/30/18).
- On 4/30/18, Individual #30 experienced a new onset seizure. The transfer to the ED happened on at 11:18 a.m. on a Monday. The reason the PCP did not conduct an acute care evaluation was unclear. However, on 4/30/18, the PCP conducted a doctor-to-doctor call with the ED physician. On 5/1/18, the PCP entered a lengthy note in Subjective, Objective, Assessment, and Plan (SOAP) format, in which the PCP documented the history, and tests and exams completed in the ED. The PCP ordered an electroencephalogram (EEG), neurological consultation, and repeat EKG. On 5/2/18, and 5/3/18, the PCP documented follow-up. On 5/5/18, the psychiatrist documented a review of the individual's QTc interval, and on 5/6/18, the psychiatrist reduced the individual's dose of Zoloft.
- On 4/12/18, nursing staff reported to the on-call PCP that Individual #93 had a fever of 100.4 degrees. The PCP ordered Tylenol, but at the time, ordered no labs, and did not see the individual. On 4/13/18 (i.e., Friday), a PCP saw the individual.

Based on the records submitted, the Monitoring Team indicated in the draft report that it was unclear if nursing staff obtained and/or reported the individual's temperatures after 4/12/18, and that on 4/14/18, it appeared nursing staff only recorded temperatures when she was shaking or exhibiting other signs of illness. In its comments on the draft report, the State disputed this finding and referenced temperatures in IView documentation. The State also indicated: "She did have at least three temperature readings daily for the next three days and her first real fever only appeared on 4-14-18 at 39.1 C (102.4F)." Although the temperatures were available in IView, given the prior temperature elevation, it would have been important for nurses to include documentation of follow-up temperatures in the subsequent nursing IPN narrative sections. However, nurses simply stated, for example: on 4/13/18, at 9:25 a.m., "F/u temp" without a temperature reading, or on 4/13/18 at 10:46 a.m., "body is warm to touch," which left open to question the presence of a fever. Nursing documentation also contradicted the State's contention that she did not have a fever until 4/14/18. For example, in the nursing IPN, dated 4/14/18, at 12:42p.m.: an LVN stated "[Individual #93] has been running a fever for the last 3 days," and the nursing IPN, dated 4/14/18, at 10:30 p.m., "has been running a fever off and on for 3 days." These important clinical omissions, and discrepancies in interpretation of temperature readings made the narrative difficult to interpret.

On 4/14/18, nursing staff reported a fever of 102 degrees. On 4/14/18, at 6:04 p.m., the on-call PCP wrote an IPN reviewing lab results. A urinary tract infection was suspected, so the PCP ordered Rocephin, but the individual had an allergy to cephalosporin, so it was changed to Bactrim. Staff had difficulty in obtaining a urine specimen, but did obtain one. By 4/15/18, she was very ill with a blood pressure of 80/60, a temperature of 103.4, and a thready heart rate of 115 to 125, and she had not voided all day. She had some diarrhea. At 11:15 p.m., on 4/15/18, the PCP ordered transfer to the ED. From 4/15/18 to 4/23/18, Individual #93 was hospitalized for sepsis, hypotension, and fever.

Based on the documentation submitted, the IDT did not hold an ISPA meeting to discuss this hospitalization, or steps to take to prevent a recurrence to the extent possible. This was concerning given that Individual #93 had sepsis with possible healthcare-acquired (HCA) pneumonia. She also had a severe bullous skin eruption due to the use of a sulfa drug (i.e., Bactrim), as well as acute kidney injury from dehydration and sepsis.

In addition, during the course of her post-hospital Infirmary stay, she, at times, refused medications and fluids. She had a mickey button, so it was unclear why it was not used to address her refusals. Her palliative care plan needed to be updated and palliative care re-consulted.

- On 9/19/18, Individual #145's PCP made a late entry for 9/14/18 at 9:15 a.m., in which the PCP documented a large amount of secretions, and oxygen saturations of 86%. The individual was receiving oxygen through a nasal cannula. Given the increased oxygen needs, and wet breath sounds, staff called Emergency Medical Staff (EMS). In addition to the PCP not entering a timely note, the PCP did not see the individual prior to the transfer, even though it was a weekday. The PCP conducted necessary follow-up upon the individual's return from the hospital.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.	
Summary: Given that over the last two review periods and during this review, for the consultations reviewed, the PCPs wrote IPNs that explained the reason for the consultation, the significance of the results, agreement or disagreement with the	Individuals:

recommendation(s), and whether or not there is a need for referral to the IDT (Round 12 – 100%, Round 13 – 100%, and Round 14 – 100%), Indicator c will move to the category requiring less oversight. It was good to see improvement with regard to PCPs completing reviews within five days. The remaining indicators will continue in less oversight.											
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.	83% 10/12	2/2	2/2	1/1	1/1	N/A	2/2	N/A	0/2	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.	100% 12/12	2/2	2/2	1/1	1/1		2/2		2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	80% 8/10	2/2	2/2	0/1	1/1		1/2		1/1	1/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	N/A									

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 12 consultations. The consultations reviewed included those for Individual #30 for endocrinology on 8/24/18, and dermatology on 9/20/18; Individual #93 for ophthalmology on 10/2/18, and endocrinology on 7/10/18; Individual #199 for gastroenterology (GI) on 5/15/18; Individual #82 for neurology on 4/26/18; Individual #145 for urology on 7/6/18, and cardiology on 8/13/18; Individual #178 for dermatology on 6/21/18, and nephrology on 7/16/18; and Individual #185 for neurology on 5/25/18, and surgery on 6/20/18.

b. Two of the reviews did not occur timely (i.e., Individual #178 for dermatology on 6/21/18, and nephrology on 7/16/18, for which it was somewhat unclear when the Center received the reports).

c. For the consultations reviewed, PCP IPNs included all of the components State Office policy requires, which was good to see.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of the following: Individual #199's GI consultation on 5/15/18, for which the PCP did not write an order for a multivitamin due to the use of magnesium and calcium; and Individual #145's cardiology consult on 8/13/18, for which the PCP did not write an order for the follow-up appointment.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: Additional work is necessary to ensure that for individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care are completed, and the PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
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.	61% 11/18	2/2	1/2	0/2	2/2	1/2	2/2	1/2	0/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #30 – diabetes, and cardiac disease; Individual #93 – diabetes, and other: palliative care; Individual #199 – GI problems, and weight; Individual #82 – falls, and seizures; Individual #187 – cardiac disease, and other: hospice care; Individual #145 – respiratory compromise, and GI problems; Individual #552 – constipation/bowel obstruction, and weight; Individual #178 – falls, and UTIs; and Individual #185 – respiratory compromise, and infections).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #30 – diabetes, and cardiac disease; Individual #93 – diabetes; Individual #82 – falls, and seizures; Individual #187 – cardiac disease; Individual #145 – respiratory compromise, and GI problems; Individual #552 – constipation/bowel obstruction; and Individual #185 – respiratory compromise, and infections.

The following provide examples of concerns noted:

- Since 2015, Individual #93 had a palliative care plan, due to her resistance to eating, as well as to staff checking her blood glucose levels, and administering medications. She also had a G-tube placed due to her malnutrition from refusing meals, as well as episodes of hypoglycemia. In the past, due to her resistance to testing, treatment, and eating, she experienced multiple restraints daily to treat her diabetes mellitus. The palliative care plan was implemented with a goal to improve the quality of her life. Palliative care consultants set up a plan to minimize the severe complications of diabetes treatment or lack of treatment, such as hypoglycemia and diabetic ketoacidosis. The G-tube was changed to a Mic-Key button, and had been used rarely, with only routine flushes weekly. She took her nourishment by mouth. The recent use of a diabetic skin patch allowed for nursing staff to measure blood glucose levels without needle sticks, and restraint use had been even further reduced.

  However, in April 2018, she was hospitalized for healthcare-associated pneumonia and sepsis. She had a severe bullous skin eruption due to use of a sulfa medication, in which approximately 20% of her skin sloughed (i.e., her upper trunk front and back, both arms and wrists, left and right buttocks, and thighs). At the hospital, she was given Morphine and then Hydrocodone. She returned to the Abilene SSLC Infirmary for three more days of Levaquin, and ongoing care, with dressing changes. Most parts of her body were affected, making keeping her comfortable a challenge. The PCP ordered Tylenol with

codeine for one week on a pro re nata (PRN, or "as needed" basis), but nursing IPNs indicated her refusal of medications, including pain medication. It was not clear how many doses she received and how pain was measured. She did receive a Toradol injection prior to wound care. She refused medications, including the Levaquin (all three doses), which put her at risk for complications/recurrence of a partially-treated pneumonia/sepsis. Early on, she refused most food and fluid. The IPNs did not make it clear how often the Mic-Key button was used, as she resisted its use. The IPNs included no mention of contacting the Palliative Care Consultants, who had seen her in 2015, to determine if pain and anxiety management could be optimized, as the IPN descriptions for her first week in the Infirmary suggested the need for optimization of pain and comfort. There did not appear to be use of comfort/palliative care measures, such as sublingual Morphine or Ativan, which might have allowed for improvement in oral intake or cooperation with medication compliance, or use of the Mic-Key button. In addition, although the Palliative Care Consultants initially saw her in 2015, and developed a plan, it was not clear if they had seen her yearly for maintenance/follow-up on her palliative care plan to determine if changes were needed, or if her needs were met. Ongoing communication and management by the consultants would allow for a rapid response to assist with acute care issues as they developed, as in this instance. As a follow-up, on 5/8/18, she was discharged from the Infirmary, and on 5/17/18, her dressings were discontinued.

- Individual #199 had diagnoses of gastritis, esophagitis, and hiatal hernia. Her past medical history included an esophageal ulcer and esophageal stenosis. On 6/30/11, she underwent a Nissen fundoplication. On 10/19/17, a Modified Barium Swallow Study (MBSS) was completed, with recommendations for a regular diet with ground meat moistened with gravy, and thin liquids. She was prescribed an anti-reflux diet. In recent months, she had occurrences of emesis followed by wheezing and hypoxia. On 5/3/18, she had emesis with wheezing and possible aspiration pneumonia, and was transferred to the Infirmary. She was started on Flovent, which improved her asthma. Other routine asthma medications included Montelukast and Zyrtec. On 5/17/18, she had emesis and developed a low-grade fever. On 6/1/18, she refused a follow-up chest x-ray. On 7/9/18, 8/20/18, 9/19/18 (admitted to Infirmary), and 10/2/18 (admitted to Infirmary), staff documented additional emesis. On 11/13/18, she vomited and again developed aspiration pneumonia and was transferred to the Infirmary.

  An ISPA, dated 5/7/18, indicated the IDT asked the OT/PT to complete a head-of-bed elevation (HOBE) evaluation. She was prescribed a proton pump inhibitor and sucralfate for her gastroesophageal reflux disease (GERD), and additionally had an antacid prescribed on a PRN basis. On 5/10/18, a PCP note indicated the chest x-ray suggested an increase in hiatal hernia size, and a referral to GI was made. On 5/16/18, an esophagogastroduodenoscopy (EGD) was completed that showed a normal fundus, body, and antrum of the stomach. The impression was a hiatal hernia. Individual #199 was often noncompliant with GERD precautions and often refused medication. Submitted data indicated she refused medications from 11 to 21 times each month. An ISPA, dated 7/18/18, indicated that the BCBA would add reinforcement for medication compliance. Plans at this ISPA included referring the individual's case to Behavioral Services Peer Review for noncompliance, and completing a review of the PBSP to develop strategies for noncompliance. When the Monitoring Team interviewed the PCP, the PCP was unaware of any involvement of Behavioral Health Services in reducing her noncompliance with taking medication or adhering to GERD precautions. This seemed to indicate a lack of collaboration between the PCP and the rest of the IDT, and/or a lack of communication with the PCP concerning findings from a review or development of strategies to address her noncompliance. Because no details were listed, it was unclear what reinforcement was added. At the time of the Monitoring Team's review, Individual #199 continued to be noncompliant with treatments for her GERD to prevent emesis, which placed her at high risk

for aspiration pneumonia/pneumonitis. Medical treatment alone is insufficient to resolve this area of her health, and the PCP should work with the IDT to identify and implement additional strategies.

- In the year prior to his death, Individual #552 experienced significant weight loss. In June 2017, the AMA indicated his weight was 129 pounds. His recommended weight range was 110 to 140 pounds. His diet was an anti-reflux diet with decaffeinated coffee and tea, pureed texture, and honey-thickened liquids. He was offered a number of supplements, including Boost with all meals, and Ensure pudding with all meals and snacks twice daily and at bedtime. Despite the diet regimen, by 4/26/18, he weighed 102 pounds, a loss of 27 pounds (21% weight loss) from 10 months prior. Over the previous year, his albumin varied from 2.9 (low) to 3.9 (normal). He had frequent refusals of his diet, and was known as a "picky eater." A PCP note, dated 4/26/18, indicated the addition of another supplement to his meals based on the dietitian's recommendation. At that time, staff observed several new findings, including blood-tinged urine and cream-colored stools. On 4/30/18, his weight further declined to 99 pounds. On 4/30/18, the PCP ordered lab testing. On 5/1/18, an abdominal x-ray showed a large pancreatic cyst, which was not a new finding. In the past, the surgeon was reluctant to remove the cystic structure.

  Based on the documentation submitted, there was little evaluation related to the weight loss over the prior year. He had a history of GERD, and it was not known if it was becoming more symptomatic. There was no information as to whether any of his medications or combinations of medications were making him anorexic. Documentation did not indicate a review of his food preferences. He was at high risk due to his anticholinergic burden (i.e., related to Ziprasidone and Valproic acid). He had several abdominal surgeries in the past, and on 5/3/18, became suddenly ill and was hospitalized. He did not survive the hospitalization for septic shock due to a bowel obstruction. Although his demise might not have been directly related to his weight loss and potential malnutrition, at the time of his hospitalization, his compromised nutritional status placed him at increased risk of a poor outcome, with an inability to fight infection and heal. It appeared the PCP, in conjunction with the IDT did not employ an aggressive approach to address the weight loss in a timely manner. No nutritional assessment was submitted for review, "as a nutrition assessment was not completed within the last 12 months." The Monitoring Team interpreted this as no nutritional assessment from October 2017 until his death in May 2018. The PCP noted that Individual #552 lost 12 pounds in three months by 5/1/18, which was a loss of over 10% of his body weight at that time. As noted elsewhere in this report, PCPs were not completing interval reviews, which might have alerted the PCP to the weight loss sooner. In addition, the IDT should have held a meeting(s) to address the weight loss, with the involvement of the PCP, but based on the documents submitted, his IDT held no ISPA meetings after his ISP, dated 6/21/17.

- In the recent past, Individual #178 fell several times, including on 5/30/18, 6/11/18, 6/28/18, 7/14/18, 8/29/18, 8/30/18, 9/24/18, 9/29/18, and 10/9/18. On 3/15/18, an audiological exam indicated Eustachian tube dysfunction and recommended return to Ear, Nose, and Throat (ENT) for consideration of ventilation tubes. On 5/29/18, he had drainage from his left ear. At that time, the PCP wrote an order for referral to ENT for possible perforation of his eardrum. However, submitted documentation through 10/1/18 did not show completion of this consult. Additionally, no information was submitted to indicate further evaluation of his falls. The PCP indicated that ataxia in this individual was at times associated with onset of illness. On 5/29/18 and 5/30/18, he was seen in the ED for abdominal pain. There was no information as to potential causes of his other falls (e.g., worn footwear, excessive length of trousers, poor vision, medication side effects, etc.). Although members of the IDT met on 7/27/18 to discuss falls (i.e., the PCP was not in attendance), the PCP, in conjunction with the IDT

did not appear to have made concerted efforts to identify the underlying causes of his falls and/or develop strategies to prevent additional falls. This placed him at significant risk.

- On 6/1/09, Individual #178 underwent a sigmoid resection and rectopexy for rectal prolapse. His post-operative course was complicated by abdominal distention and vomiting. On 6/5/09, he underwent an exploratory laparotomy to determine a cause, but it revealed no hemorrhage, infection, obstruction, or perforation. He then developed pneumonia. On 6/28/09, a computed tomography (CT) scan identified a large left-sided abdominal fluid pocket, and on 7/2/09, a repeat CT scan of the abdomen revealed three separate urinomas, which were found to be due to injury to his left distal ureter. On 7/17/09, he underwent a left nephrectomy. Since that time, he had a small bowel obstruction treated conservatively. Most recently, on 5/13/18, he was hospitalized for fever and a distended abdomen. He was found to have urosepsis, which responded to Levaquin. A 5/25/18 post-hospital review was completed for his UTI and chronic anemia. His remaining right kidney had a renal cyst, which had increased in size. A CT scan, dated 5/18/18, indicated significant bladder wall thickening and prostatic hypertrophy. At that time, nephrology was consulted as the individual's glomerular filtration rate (GFR) had dropped. Urology was also consulted for consideration of a cystoscopy. Submitted documentation did not provide evidence that a urology consultation was completed, although it had been four and a half months since the consult was ordered. During the onsite review, the PCP was not aware of the lack of follow-through on the urology consult until discussing the individual's health with the Monitoring Team member. Without further evaluation, it was unclear if preventive steps could be taken to reduce recurrence of the UTIs or to rule out other urological concerns (e.g., urinary retention from bladder wall atony, ureteral reflux, obstructive uropathy from prostatic hypertrophy, etc.).

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

Summary: It was concerning that at this juncture, IHCPs did not include action steps for PCPs to address individuals' medical needs. 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: 30	93	199	82	187	145	552	178	185
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	N/A									

Comments: a. Individuals' IHCPs did not include action steps to address individuals' medical needs.

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	30	93	199	82	187	145	552	178	185
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	Not rated (N/R)									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: a. and b. The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: Given that practitioners generally implemented agreed-upon recommendations from QDRRs during this review and the past two reviews (Round 12 – 80%, Round 13 – 100%, and Round 14 - 100%), Indicator d will move to the category requiring less oversight. Overall, QDRRs addressed many of the necessary components. The components needing continued focus were lab results, and the risk of metabolic syndrome due to the use of new generation antipsychotics.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	83% 15/18	2/2	2/2	2/2	1/2	2/2	2/2	1/2	1/2	2/2
	ii. Benzodiazepine use;	100% 12/12	N/A	N/A	2/2	2/2	2/2	2/2	2/2	2/2	N/A
	iii. Medication polypharmacy;	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1
	iv. New generation antipsychotic use; and	70% 7/10	2/2	2/2	2/2	N/A	N/A	N/A	1/2	0/2	N/A

	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 4/4	N/A	N/A	N/A	N/A	N/A	1/1	1/1	1/1	1/1
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: b. According to a lab, dated 4/11/18, Individual #82's Vitamin D level was low, but in the QDRR, dated 5/1/18, the Clinical Pharmacist did not make a recommendation to the PCP to increase the dosage.

For Individual #552:

- The QDRR, dated 1/16/18, indicated he had no risks related to metabolic syndrome, but he was at risk due to elevated blood sugar.
- In the QDRR, dated 4/23/18, the Clinical Pharmacist did not review the most recent Valproic Acid level available.

For Individual #178:

- In the QDRR, dated 5/2/18, the Clinical Pharmacist did not address the low potassium level from a lab, dated 2/23/18.
- Neither QDRR identified the full list of the individual's risk factors for metabolic syndrome. Specifically, he was treated for high blood pressure, and this should have been listed as one of the risk factors, but was not.

d. It was positive that when prescribers agreed to recommendations for the individuals reviewed, documentation was presented to show they implemented them.

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

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, for individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	50% 2/4	N/A	N/A	N/A	1/1	N/A	1/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/4				0/1		0/1		0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/4				0/1		0/1		0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/4				0/1		0/1		0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/4				0/1		0/1		0/1	0/1

Comments: a. and b. Individual #30, Individual #93, and Individual #552 were edentulous, but they were part of the core group, so full reviews were conducted. Individual #199, and Individual #187 were also edentulous, placing them at low risk for dental concerns. Because they were part of the outcome group, a limited review was conducted for them. The Monitoring Team reviewed four individuals with medium or high dental risk ratings.

In reviewing Individual #82's IRRF and IHCP, his IDT came close to developing a clinically relevant, achievable, and measurable goal/objective related to dental. The IDT included an "outcome" that required 80% compliance with tooth brushing, and later in the IHCP, included an "intervention" that indicated he should brush his teeth twice daily. To make the stand-alone goal/objective measurable, it should have included both criteria (i.e., 80% of the twice daily trials), but it was good that the IDT defined the number of daily trials in the intervention section. However, what was missing from a measurability perspective were the criteria for successful completion: 1) for how long did he need to brush his teeth each trial (e.g., 30 seconds, two minutes); and 2) for how many weeks/months did he need to reach/maintain the 80% threshold (e.g., for three consecutive months). Based on review of the IRRF, data showed a lack of tooth brushing twice a day was likely contributing to his dental issues (e.g., decrease in oral hygiene rating from fair to poor, periodontitis). Therefore, the goal/objective was considered clinically relevant.

The same was true for Individual #145 (i.e., goal/objective for tooth brushing 75% monthly, and intervention for twice a day, but criteria for success missing).

For Individual #185, IDTs had not defined the frequency of tooth brushing, so clinical relevance could not be determined.

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

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

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: Individual #30, Individual #93, Individual #199, Individual #187, and Individual #552 were edentulous.

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 and/or implemented a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: The two individuals reviewed with medium or high dental caries risk received fluoride applications twice per year. If the Center sustains this performance, after the next review, Indicator d might move to the category of less oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185

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.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.										
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.										
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	N/A				N/A		N/A		N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									

Comments: d. through f. Individual #30, Individual #93, Individual #199, Individual #187, and Individual #552 were edentulous.

e. On 3/22/18, Individual #178's annual dental exam identified a caries to tooth #15. On 4/2/18 and 4/18/18, the Dentist completed additional assessment, but the individual could not tolerate the restoration process. The Dentist applied "advantage arrest," and indicated the individual would need general anesthesia to restore the tooth. They were waiting for the individual to show stability for six months. He had an appointment scheduled for 12/5/18. The indicator was scored N/A, because the restoration has not yet been completed, but it was not yet overdue (i.e., the audit tool states that restorations: "can occur within one year of identification of need or at the time of the individual's next sedation").

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: Based on the one dental emergency reviewed, the dentist provided the individual with timely dental assessment and care, including pain management. Given that during this review and the last review, individuals received timely and complete emergency dental care (Round 13 – 100%, and Round 14 - 100% for all three indicators), Indicators a through c will move to the category requiring less oversight. (Of note, in Round 12, documentation was not complete to determine the timeliness of the dentist's response to the one dental emergency reviewed, but the individual did not need treatment or pain management.)			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A

b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1								1/1	
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 1/1								1/1	
Comments: a. through c. through c. On 2/28/18, at 4:24 p.m., nursing staff notified the Dental Office of Individual #178's dental complaints. On 3/1/18, at 9:59 a.m., the dentist saw him for an exam. The dentist completed x-rays. The assessment was acute myofascial pain due to bruxism. The individual was not a candidate for a bruxism appliance due to the poor prognosis for wearing it. The dentist provided Tylenol for pain.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: Considerable work is needed to ensure that individuals' ISPs define the suction tooth brushing that they need, the suction tooth brushing occurs as planned, and Dental Department staff conduct monitoring at a frequency that IDTs determine. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
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% 0/3	N/A	N/A	N/R	N/A	N/R	0/1	0/1	N/A	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/3						0/1	0/1		0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3						0/1	0/1		0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/3						0/1	0/1		0/1

Comments: For Individual #199 and Individual #187, a limited review was conducted.

a. Individual #145, and Individual #185's ISPs/IHCPs included goals/objectives or interventions related to tooth brushing, but they were not measurable, because they did not include the expected duration (e.g., for 30 seconds, for two minutes, etc.). Individual #552's ISP/IHCP did not include a dental goal or measurable strategies related to suction tooth brushing.

b. For Individual #552, the Dental Director indicated that the Center could not provide data, because the individual was dead and staff could not retrieve archived information. After individuals die, data still need to be available.

For Individual #145 and Individual #185, ISPs did not include measurable objectives. Based on the data submitted, it appeared that although staff documented completion of tooth brushing, it often was not completed for two minutes, and Individual #145's data

showed many days on which it did not occur at all even after removing dates of hospitalizations.

c. Although it appeared that Dental Department staff conducted some monitoring of staff's implementation of suction tooth brushing for quality, as well as safety, ISP action plans did not define the frequency expected of monitoring to meet the individuals' needs. As a result, the Monitoring Team could not determine whether or not the frequency was sufficient.

Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." Moving forward, IDTs should ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring and it is implemented according to the schedule.

d. For the three individuals, QIDP reports did not include data related to tooth brushing. Moving forward, specific suction tooth brushing data is needed to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). Additionally, a second data subset is needed on the number of such events during which the individual completed the expected duration of suction tooth brushing (e.g., of the 60 completed sessions, in 12 sessions the individual completed two minutes of suction tooth brushing).

Outcome 9 – Individuals who need them have dentures.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	If the individual displays signs and symptoms of an acute illness	0%									

	and/or acute occurrence, nursing assessments (physical assessments) are performed.										
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									
Comments: a. through f. In the months prior to the review, State Office provided training to all of the Centers on the development of acute care plans. During this round of reviews, the Monitoring Team is working with State Office on ensuring Centers provide the correct documentation for review of acute care plans. Given the timing of the Abilene SSLC review, the Center was in the initial stages of implementing the revised acute care plan template/process. It was decided that the Monitoring Team would not search for needed acute care plans that might not exist throughout the preceding six months. However, as a result of the ongoing systems issue since the implementation of IRIS, these indicators do not meet criteria. Center staff should continue to work with State Office to correct the issues. By the time of the next review, the Monitoring Team plans to conduct a full review of acute care plans.										

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
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.	6% 1/18	0/2	0/2	1/2	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/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #30 – skin integrity, and other: sequelae from victimization related to peer-to-peer aggression; Individual #93 – constipation/bowel obstruction, and UTIs; Individual #199 – falls, and weight; Individual #82 – falls, and constipation/bowel obstruction; Individual #187 – choking, and hypothermia; Individual #145 – constipation/bowel obstruction, and osteoporosis; Individual #552 – constipation/bowel obstruction, and choking; Individual #178 – skin integrity, and falls; and Individual #185 – UTIs, and constipation/bowel obstruction).

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #199 – weight.

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

Outcome 6 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Summary: Nurses often did not include interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
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% 0/13	0/2	0/1	0/2	0/1	0/2	0/1	0/2	0/2	N/A
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	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. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly.

b. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- Center staff submitted data reflecting that from 4/25/18 through 10/8/18, Individual #30 was a victim of peer-to-peer aggression 21 times. However, documentation was not presented to show that the IDT took prompt action to protect her from peers hitting and pushing her, which placed her at significant risk for injuries and neurological issues. An ISPA, dated 7/23/18, noted that Individual #30 had been identified as a high-frequency victim, but the IDT did not document any analysis in the ISPA to identify trends, patterns, or associated factors to assist in developing supports to prevent further aggressions by peers. Documentation did not show that the IDT analyzed and/or addressed the following in relation to the peer-to-peer aggressions:
    - Data from the QIDP monthly reviews and Document #TX-AB-1811-IV.1-20 reflected that from 4/25/18 through 10/8/18, she had at least 21 peer-to-peer episodes. A number of these episodes warranted "mild neuro checks" due to hits to her head.
    - The following existing issues placed her at a higher risk for being a victim: her significant hearing loss, vision issues, diabetes and frequent episodes of hypoglycemia, frequent episodes of falling asleep, episodes of being unsteady and tripping and/or falling, her obsessive-compulsive disorder (OCD) diagnosis, and on 4/30/18, the new onset of a seizure.
    - There was no indication that the IDT reviewed sleep issues in spite of the fact that the QIDP monthly reviews indicated that from 5/7/18 to 9/14/18, staff found her she asleep on the toilet at least 10 times.
    - Staff frequently found she had bruises/abrasions/scratches without explanation.
    - The IDT had not analyzed her frequent (41) episodes of hypoglycemia, and comparted them with other health and behavioral issues.
    - According to the QIDP monthly reviews, she was having more episodes of unsteady gait and falls.
    - On 4/30/18, she had a seizure with no previous history of seizures.

  In sum, despite these data, the IDT did not act with a sense of urgency to protect her from injury and harm. According to the ISPA, dated 7/23/18, the IDT's plan was to retrain staff to redirect peers and intervene "instead of just reacting," increase activities out of the home "to keep them engaged and away from each other," and put paper and markers on a table to give Individual #30 something to do and "knowing where she is at [sic] might help staff keep her safe." No follow-up ISPA was found noting if these interventions were effective in keeping her safe.
- Data the Center provided in response to Document Request #TX-AB-1811-IV.1-20 indicated that from 4/12/18 through 11/12/18, Individual #93 received at least 25 PRN medications for constipation. The nursing annual and quarterly record reviews indicated that one of the root causes of her constipation was her food and fluid intake, which the IDT also identified as a factor in her weight issues, UTIs, and her issues with diabetes. However, a review of the documentation provided from the direct support professionals and nursing staff indicated that staff were not tracking and monitoring her daily fluid intake, even though she had frequent food/fluid refusals, which had the potential to affect her other health and behavioral issues. Also, based on review of the ISPAs provided, her IDT had not conducted a comprehensive review of this issue in an effort to prevent these frequent episodes of constipation. It was unclear from the documentation if the IDT was even aware of the number of

times she was experiencing constipation. For example, an IPN, dated 8/2/18, from the PCP noted that the RN reported concerns about constipation and her need for suppositories "on occasion." Apparently, the PCP was not aware of how often she was receiving PRN medications for constipation, which was extremely concerning. In addition, a review of the nursing monthly risk reviews for August and September 2018 indicated that in spite of the significant number of PRN medications for constipation she regularly received, since Individual #93 was free of hospitalizations related to bowel issues, her goal addressing constipation was met. At the time of the Monitoring Team's review, there was no indication that the IDT had a plan to review, and analyze data, and implement interventions to aggressively address this ongoing health issue.

- Although Individual #199 had not experienced a fall, based on documentation provided, it did not appear that her IDT was monitoring and tracking factors that placed her at a higher risk for falls in an effort to proactively prevent future falls from occurring. Problematic issues included:
    - From the documentation provided, it was not clear when she began using a wheelchair for mobility, and if its use had increased over a period of time, indicating that walking was problematic for her.
    - Her IDT did not conduct a regular systematic review of her health/behavioral issues such as pain, depression, sleep issues, medication effects, changes in endurance, effects of her medical diagnoses, episodes of lower extremity edema, episodes of chest pain, vomiting episodes, respiratory issues from dysphagia and asthma, blood pressure values, lab values, weight, and GI issues, and their effects on her mobility.
- Regarding Individual #199's risk related to weight, information in the IRRF noted a 29.5 weight gain since last year with 71 episodes of emesis (an increase from the past year of 44) after eating foods not on her diet. However, the IDT documented no analysis regarding why she experienced an increase in weight and vomiting, or provide any summary related to changes in activity levels or other factors that might have had an effect on her weight. Although it was not clear from the ISPAs provided, due to problems with the provision of dates, the IDT noted that as of May (no year provided), she had lost 13 pounds since June 2016. However, the IDT provided no details about how this had occurred (e.g., better compliance with her diet, more activities, decrease in edema, vomiting episodes). Such information would be significant in evaluating and analyzing her current weight and health issues. Also, her baseline of caloric intake as well as activity level were not stated, or how this changed over time. The IDT had not developed an assertive plan to address her weight issue.
- Based on review of the ISPAs provided, Individual #82's IDT had not reviewed and analyzed his falls. The Center's response to Document Request #TX-AB-1811-IV.1-20 indicated that from 4/10/18 through 10/4/18, he fell 19 times. The IRRF and nursing annual record review noted that some of his falls were associated with his seizure activity. However, there was no indication that the IDT reviewed and analyzed these data (falls and seizures). Although the documentation indicated that the PT worked with him and discontinued his therapy in September 2018, when he met his goal, Individual #82 continued to have falls. Given that the falls placed him at high risk for injury, it was concerning that the IDT had not thoroughly reviewed the data to identify the etiology(ies) of his falls, and implemented actions to reduce his risk to the extent possible.
- The Center's response to Document Request #TX-AB-1811-IV.1-20 indicated that on 4/27/18 (35.4 C = 95.7 F), 7/9/18 (35.4C = 95.7 F), and 8/2/18 (35.3C = 95.5 F), Individual #187 had three episodes of hypothermia. However, the IDT had not developed and implemented an IHCP for this issue. In addition, the nursing quarterly record reviews, the IRRF, the PNMP, the monthly nursing IPNs, and/or the ISPAs did not mention them. The AMA, dated 2/23/18, did not indicate that he had experienced episodes of hypothermia in the past. In addition, the documentation submitted did not show that the IDT was collecting, reviewing, and analyzing data related to his symptoms of bluish color skin, lips and tongue, or sleep issues, pain, fatigue, oxygen levels, chest pain, need for supplemental oxygen, sweating, changes in endurance, and ability to feed himself

(i.e., as noted in the AMA related to his diagnoses of Tetralogy of Fallot with Eisenmenger Syndrome and Polycythemia secondary to hypoxemia). As a result, it was unclear how his IDT was tracking his status.

- Based on the data the Center provided in response to Document Request #TX-AB-1811-IV.1-20, from 5/4/18 through 10/13/18, Individual #145 had 13 episodes of constipation. Although the individual received his nutrition through gastrostomy tube (G-tube), the documentation submitted did not show that the IDT reviewed or analyzed factors such as fluid intake, residuals, positioning, episodes of emesis, or medications to determine the need for interventions to decrease his episodes of constipation.
- In response to the Monitoring Team's request, Center staff provided no ISPAs for Individual #552. Thus, there was no indication that the IDT met regularly to discuss, review, and analyze the changes in his health status leading up to his death on 5/11/18. Based on the Monitoring Team's review of the IView documentation provided, there was a significant lack of nursing assessment data to address this individual's health status, including, for example, assessments related to constipation, skin and dehydration, mental status, activity levels, urine output, and daily food and fluid intake. His IDT did not add requirements to his IHCPs for nursing assessments, or increase the frequency of assessments as his status changed with increasing acute events. In addition, based on review of the IView entries, nursing quarterly record reviews, nursing IPNs, and PCP IPNs, the daily totals of his intake were not mentioned. Only a few IPNs noted either the ounces and/or milliliters that he consumed for that shift or medication pass. This was in spite of a nursing IPN, dated 4/27/18, noting "very dark tea colored urine" and cream colored stool, as well as a statement that the PCP indicated nurses should watch for decreased fluid intake, decreased bowel sounds, and abdominal distention. The PCP IPN, dated 4/30/18, noted that: "He doesn't have any abundance of saliva though and may have had a poor intake of fluids the past few days." Again, no specific daily intake totals were found. Although fluid intake was only one factor that might have contributed to Individual #552's health issues, without this basic data, his IDT could not sufficiently evaluate other factors such as changes in sodium levels, mental status, bowel status, diet change to a full liquid diet, medication levels, and issues related to absorption.
- Individual #178's IRRF noted he fell 19 times the previous year and seven times during the current year. In the documentation provided, the IDT provided no analysis of falls, including, but not limited to the identification of trends or patterns. The IDT rated him at medium risk (i.e., the same as previous year). The IDT's justification was that his risk level would remain the same, since he had less falls than the previous year. However, they did not consider that in 2016, his DEXA score worsened in comparison with his score in 2014, placing him at increased risk for fractures/injuries. Since the ISP meeting, on 5/10/18, according to the Center's response to Document Request #TX-AB-1811-IV.1-20, he fell at least an additional 10 times (i.e., on 5/30/18, 6/28/18, 7/12/18, 7/14/18, 7/25/18, 8/29/18, 8/30/18, 9/24/18, 10/1/18, and 10/9/18). The nursing quarterly record review, dated 7/31/18 through 10/8/18, noted some different dates for falls, so it was unclear how many additional falls he actually had.

  An ISPA, dated 10/22/18, indicated that the IMRT was concerned about Individual #178's falls and requested that the IDT meet. However, the documentation from the subsequent ISPA reflected a lack of urgency. For example, the IDT did not pursue an additional evaluation for Eustachian tube dysfunction, even though the note clearly indicated that the IDT felt that this was the "major factor" exacerbating his loss of balance. Back in April 2017, 18 months prior to the ISPA meeting, the physician who completed the initial consultation did not agree to surgical correction. ISPAs provided no indication what, if any, interventions the IDT actually implemented to keep the individual safe from falls, while the IDT decided on a course of action.

Outcome 7 – Individuals receive medications prescribed in a safe manner.											
Summary: For at least the two previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; and 2) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, these indicators will continue in active oversight until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will continue in active oversight as well.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 6/6	1/1	1/1	N/R	1/1	1/1	N/R		1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	57% 4/7	N/A	1/1	1/1	1/1	0/1	1/1	0/1	N/A	0/1
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	33% 1/3	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	0/2

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.	83% 5/6	1/1	1/1		1/1	1/1			1/1	0/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 6/6	1/1	1/1		1/1	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 six individuals, including Individual #30, Individual #93, Individual #82, Individual #187, Individual #178, and Individual #185. Individual #93 requested that the Monitoring Team not observe her medication pass. Individual #145's home was on isolation. Individual #552 had passed away.

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.

The medication nurse did an excellent job when working with Individual #93. She was able to obtain a finger stick for blood sugar (i.e., the Libre monitor had fallen off of the individual's arm) and administer her Insulin without the use of restraint. However, this nurse was not usually assigned to Individual #93's home and was unfamiliar with the Free Style Libre device. All staff working with this individual should complete training, and informational materials regarding the device should be assessable in the home. The use of this device has essentially eliminated the need to restraint Individual #93 to obtain her blood sugars. The IDT and other Center staff are commended for initiating this procedure to meet the needs of this individual.

d. According to Individual #187, Individual #552, and Individual #185's IHCPs, nursing staff were to assess lung sounds monthly.

However, their risk levels were "high" and monthly lung sound assessments were not frequent enough for this level of risk.

f. Often, medication nurses used the individuals' PNMPs and checked the position of the individuals prior to medication administration. The exception was that the medication nurse did not verify Individual #185's position for medication administration. She relied on the direct support professional, and when the Center observer prompted her to verify the position, she was not familiar with how to change the position of his cart, indicating that she likely had not been verifying his position prior to medication administration.

g. For the individuals observed, nursing staff followed infection control practices, which was good to see.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: The Center needs to make significant improvements with regard to IDTs referring individuals to the PNMT, when needed, and/or the PNMT making self-referrals. In addition, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
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;	11% 1/9	1/2	N/A	N/A	0/1	0/2	0/1	0/1	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/9	0/2			0/1	0/2	0/1	0/1	0/1	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9	0/2			0/1	0/2	0/1	0/1	0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/9	0/2			0/1	0/2	0/1	0/1	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/2			0/1	0/2	0/1	0/1	0/1	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;	22% 2/9	N/A	0/2	2/2	0/1	N/A	0/1	0/1	0/1	0/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9		0/2	0/2	0/1		0/1	0/1	0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/9		0/2	0/2	0/1		0/1	0/1	0/1	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9		0/2	0/2	0/1		0/1	0/1	0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/9		0/2	0/2	0/1		0/1	0/1	0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/9		0/2	0/2	0/1		0/1	0/1	0/1	0/1

Comments: The Monitoring Team reviewed nine goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #30 - choking, and falls; Individual #82 – choking; Individual #187 – aspiration, and choking; Individual #145 – skin integrity; Individual #552 – choking; Individual #178 – choking; and Individual #185 – GI problems.

a.i. and a.ii. The IHCP that included a clinically relevant goal/objective was for: Individual #30 - choking. It related to adhering to texture and dining techniques, but it was not measurable.

b.i. The Monitoring Team reviewed nine areas of need for seven individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included for: Individual #93 – choking, and weight; Individual #199 – aspiration, and GI problems; Individual #82 – falls; Individual #145 – aspiration; Individual #552 – GI problems; Individual #178 – falls; and Individual #185 - aspiration.

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

- Individual #93 had a diagnosis of Parkinson's Disease, progressive neurological decline, and was experiencing the effects of poorly controlled diabetes. Due to the progressive nature of her condition, along with the multiple physical and nutritional management (PNM) issues she exhibited as detailed in the 9/4/18 ISPA (e.g., coughing, gagging, unplanned weight loss of 19 pounds in 14 months), the PNMT should have at least conducted a review. Although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined at a minimum according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. This individual's continuing decline placed her at significant risk of harm.
- Despite 16 falls between April 2018 and September 2018, Individual #82's IDT did not refer him to the PNMT, and the PNMT did not make a self-referral, or conduct a review. Nine of the 16 falls occurred between June 11, 2018 and September 13, 2018.

This represented a significant change in status, because according to the 2017 OT/PT update the number of falls increased from three in 2015 to 10 in 2016, and now in approximately five to six months, he fell 16 times.

- Individual #145 had multiple pneumonias throughout the past year (i.e., 11/14/17, 12/12/17, 3/19/18, 8/4/18, 8/28/18, and 9/14/18). There was no evidence that the IDT made a formal referral, and although PNMT minutes stated the issue, the PNMT conducted no formal review or assessment. Due to the ongoing nature of the pneumonia, which negatively impacted the individual's lungs, a PNMT referral and assessment was warranted.
- On 10/3/17, when Individual #552 had a fever secondary to an ileus, and returned from hospital after an emesis event on 1/12/18, in which fecal material was found, his IDT did not make a referral to the PNMT, and the PNMT did not conduct at least a review. The reason the PNMT gave for not reviewing the fever was that the ileus was noted to be medical in nature. Given the resulting fever as well as the PNMT minutes showing that on 1/18/18, Individual #552 met the threshold for referral and review, it was not clear why they did not conduct one. PNMT minutes for January, February, and March 2018 only stated that the individual had a small bowel obstruction.
- Individual #178's IDT did not make a referral to the PNMT despite 12 falls since April 2018. Six of these falls occurred after 7/23/18, when the IDT held an ISPA meeting to discuss falls. At the ISPA meeting on 7/23/18, the IDT did not develop an action plan that addressed the etiology of his falls, and after the meeting, the IDT did not conduct follow-up. For example, the OT stated that the PT would be consulted, but there was no evidence of this being done. As stated above, although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined <u>at a minimum</u> according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. This individual's continuing falls placed him at significant risk of harm.
- Individual #185 had a history of aspiration pneumonia (i.e., 2/25/17, and per the PNMT minutes, 12/12/17), but his IDT did not make a referral, and the PNMT did not provide a review. PNMT minutes, dated 12/17/17, stated that the individual returned from the hospital, and the PNMT discussed him, but he did not meet criteria. However, given his history, the PNMT minutes did not document the specific discussion or rationale for the PNMT not conducting at least a review. Such discussion also was not found in IPNs, or ISPAs.

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

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.	
Summary: Data generally were not included in monthly integrated reviews to confirm the implementation of PNM action steps. In numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they	Individuals:

experienced changes of status. These indicators will remain in active oversight.											
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
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.	10% 1/10	0/1	0/2	1/2	0/1	N/A	0/1	0/1	0/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	N/A									

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews generally did not provide specific information or data about the status of the implementation of the action steps that were included.

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

- Despite a history of and ongoing issues with falls, Individual #30's IDT rated her at low risk (without clinical justification), and did not develop an IHCP. Based on nursing IPNs, she fell on 9/28/17, 12/1/17, 12/15/17, 1/10/18, 2/17/18, 3/12/18, 4/30/18 at which time she sustained lacerations, 5/11/18, 8/1/18, and 8/25/18.
- On 9/4/18, Individual #93's IDT determined through a "root cause" analysis meeting that her food texture would return to whole, and staff would chop the food in front of her, as opposed to serving chopped food. This was a strategy to address her weight loss. However, given the potential increase in her choking risk, the IDT should have, but did not increase monitoring during mealtimes. Moreover, despite an unplanned 19-pound weight loss in approximately 14 months (i.e., as the IDT documented in the "root cause analysis"), her IDT did not develop an IHCP related to weight as part of her ISP, dated 8/16/18. It was not until the final "root cause analysis" meeting, on 9/19/18, that the IDT agreed to increase the risk rating to medium, and develop a goal/objective. However, the goal/objective was not clinically relevant, because it did not address the etiology of the weight loss.
- For Individual #199, a HOBE evaluation was requested on 5/7/18, but none was submitted in response to the Monitoring Team's document request.
- Despite 16 falls between April 2018 and September 2018, Individual #82's IDT did not hold an ISPA meeting to discuss the falls, modify his IHCPs, and/or refer him to the PNMT. This represented a significant change in status, because according to the 2017 OT/PT update the number of falls increased from three in 2015 to 10 in 2016, and now in approximately five to six months, he fell 16 times.
- Individual #145 had multiple pneumonias throughout the past year (i.e., 11/14/17, 12/12/17, 3/19/18, 8/4/18, 8/28/18, and 9/14/18). As discussed elsewhere in this report, the IDT did not refer him to the PNMT. Moreover, the IDT did not meet to discuss his 8/4/18 pneumonia. Although the IDT met to discuss the 8/28/18 pneumonia, the IDT did not review the PNMP or its implementation, and the IDT made no recommendations for Habilitation Therapies staff to conduct further review.

• Despite Individual #552's ongoing issues with emesis, including an episode in which fecal matter was found in the emesis, his IDT did not discuss how positioning might play a role in bowel management.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Overall, PNMP/Dining Plan implementation at Abilene SSLC showed improvement (i.e., Round 11 – 33%, Round 12 – 31%, Round 13 – 38%, and now, Round 14 – 61%). While this is movement in the right direction, efforts are still needed to continue to improve Dining Plan implementation, and positioning. Often, the errors that occurred (e.g., eating at an unsafe rate, missing equipment designed to prevent skin breakdown) placed individuals at significant risk of harm. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	61% 28/46	
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.	67% 2/3	
Comments: a. The Monitoring Team conducted 46 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 17 out of 27 observations (63%). Staff followed individuals' dining plans during 10 out of 18 mealtime observations (56%). Staff completed transfers correctly during one out of one observations (100%).			

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A		N/A				N/A			N/A

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: Most individuals reviewed did not have clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	38% 3/8	0/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	38% 3/8	0/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	25% 2/8	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/7	0/1	0/1	1/1	0/1	0/1	N/A	0/1	0/1	

Comments: a. and b. Individual #185 did not need formal OT/PT services due to a limited ability to actively engage in therapy. Informal programs were developed to address range-of-motion (ROM) and sensory awareness.

The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #199 (i.e., to use a resistance band to complete leg exercises), and Individual #145 (i.e., to independently move a chair).

The goal/objective that was clinically relevant, but not measurable was for Individual #82 (i.e., stepping over eight obstacles), because the individual's baseline was not established in the goal/objective.

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #187's goal/objective to move his wheelchair using his hands.

c. through e. From June 2018 through August 2018, Individual #199 often refused to complete her goal/objective related to using a

resistance band to complete leg exercises. It was positive that her IDT met to review the lack of progress, and decided to change the frequency to twice daily, and implement a reward system for completing the exercises. Although data were limited after this change, it appeared to have assisted in increasing the individual's participation in the goal/objective. However, because she had not achieved the desired outcome, a full review was conducted.

Individual #145's goal/objective was new, and as a result, a sufficient amount of time had not elapsed to determine if he met it.

For the remaining individuals, in addition to a lack of clinically relevant, achievable and/or measurable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals.

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

Summary: For the individuals reviewed, evidence often was not found in ISP integrated reviews to show that OT/PT supports were implemented. It was positive that for the one OT/PT support that was terminated, the IDT held an ISPA meeting to discuss and approve the change. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	50% 2/4	N/A	N/A	1/1	0/1	0/1	1/1	N/A	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments: a. For Individual #82, the QIDP integrated reviews did not include a review of his goal/objective to step over obstacles.

For Individual #187, based on the documents submitted, his mobility goal had not been implemented since July 2018.

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 and the Center's varying scores (Round 11 – 63%, Round 12 – 91%, Round 13 - 77%, and Round 14 – 95%), 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 total is listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	140	484	138	503	465	122	312	609	415
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	95% 35/37	1/1	1/1	1/2	2/2	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		525	344	206	73	223	203	493	382	541
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	2/2	1/1	0/1	1/1	1/1	1/1	2/2	3/3
		Individuals:									
#	Indicator		275	290	506	443	395	71	185	282	199
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	2/2	2/2	1/1	1/1	2/2	1/1	1/1
		Individuals:									
#	Indicator		566								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								
Comments: c. The Monitoring Team conducted observations of 37 pieces of adaptive equipment. Based on observation of Individual #138, and Individual #73 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, and communication. One of these was moved to, or was already in, the category of requiring less oversight after the last review. Presently, three of these indicators in the area of skill acquisition will move to the category requiring less oversight. This includes the entirety of Outcome #6 in skill acquisition.

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

In the ISPs, without personal goals that are individualized, measurable, and then implemented, and, for which data are collected, it is impossible to determine progress. IDTs were not addressing barriers to:

- Implementation of action plans in a timely manner.
- Achieving goals, especially related to communication skills.

Direct support professional staff interviewed and observed throughout the week were knowledgeable about individuals' preferences and support needs and very respectful and supportive to each individual in their interactions.

Most individuals had limited time scheduled out of their homes. Work is often limited to stacking or folding linens. Staff are encouraged to explore a much broader range of work options, both on campus and in the community.

The behavioral health services department clinical director and program development specialists accompanied the Monitoring Team to scheduled SAP observations. This resulted in good onsite review and discussion regarding the development of meaningful and functional skills, and consideration of different teaching methodologies.

Individuals were not making progress on their SAPs and actions were rarely taken in these cases. None of the SAPs contained all of the required components, but many components were in every SAP.

The number of individuals observed to be engaged by the Monitoring Team and the number observed to be engaged by the Center were higher than at the last review. Abilene SSLC regularly measured engagement.

It was good to see collaboration/integration with the public school.

It was concerning that often individuals' AAC devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. The Center should focus on improvements in these areas.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Without personal goals that are individualized, measurable, and then implemented, and, for which data are collected, it is impossible to determine progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	437	93	231	145	187			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
4-7. For personal goals that did not meet criterion as described above, there was no basis for assessing progress in these areas.

For the nine 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 any of the goals (i.e., indicator 3).

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

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	437	93	231	145	187			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	25% 1/4	0/1		0/1	1/1		0/1			
40	Action steps in the ISP were consistently implemented.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									

Comments:
39. Direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs and very respectful and supportive to each individual in their interactions.

The staff for one individual were found to exhibit a level of competence to ensure implementation of the ISP (as per the criteria for this indicator). This was staff for Individual #231.

Individual #437's programming was on hold due to his broken finger, therefore, the Monitoring Team was unable to observe staff implementing his action plans. Individual #145's home was quarantined due to the flu; therefore, the Monitoring Team was unable to interview staff or observe staff implementing his ISP.

For the other three individuals, staff were not fully implementing ISPs, so it was difficult to verify that they could exhibit competence in implementing support plans. ISPs rarely included detailed instructions to guide staff when implementing the ISP. As noted throughout this section of the report, ISPs often included SOs that did not have specific implementation methodologies and this contributed to the lack of implementation.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report.

Going forward, IDTs need ensure all staff have instructions for carrying out action plans and then monitor the implementation of all action plans and address barriers to implementation.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Performance remained low, that is, individuals were not making progress on their SAPs and actions were rarely taken in these cases. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
6	The individual is progressing on his/her SAPs.	8% 2/25	0/2	0/3	0/3	1/2	0/3	0/3	1/3	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A									
8	If the individual was not making progress, actions were taken.	14% 3/21	1/2	0/3	0/3		1/3	0/3	1/2	0/2	0/3
9	(No longer scored)										

Comments:
6. Based upon a review of data presented in the text of the QIDP Monthly Reports and graphically in the Client SAP Training Progress Note, it was determined that progress was being made on two SAPs (Individual #479 - sign language, and Individual #231 - food choice).

Data on two other SAPs (Individual #479 - pedestrian safety, and Individual #549 - letter) suggested progress, but the data reliability could not be assured.

Data on all other SAPs reflected a lack of progress. Note that for seven SAPs (Individual #30 - apply lotion and wash hands, Individual #437 - daily schedule and use computer, and Individual #93 - shower, shopping list, and express feelings) less than half of the scheduled training sessions were conducted in three or more months over the six-month period.

7. The objective was not met in any of the SAPs, therefore, this indicator was not applicable.

8. There was evidence of corrective actions taken for three SAPs in which the individual was not making progress. A revision was made to the reinforcer applied for correct responding in Individual #30's washing hands SAP. Staff were re-trained in implementing Individual #93's expressing her feelings SAP and Individual #231's relaying information in an emergency.

In some cases, the only identified action was to discontinue the SAP. This included all three of Individual #437's SAPs, Individual #526's personal space SAP, and Individual #549's scrapbook and letter SAPs.

It was suggested that Individual #93's lack of progress was a result of dementia like symptoms, along with a decline in her cognitive abilities due to aging and diabetes. Unless these changes have been assessed, such speculation distracts the team from identifying and attempting revisions to ensure progress. Reference to "dementia-like behavior" was also noted in the final root cause analysis report from September 2018. It was agreed that the IDT needed to collect more data to determine a root cause to her increased problem behaviors. Until this suspected change in her behavior is objectively verified, staff should avoid using such terms.

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

Summary: None of the SAPs contained all of the required components, but many components were in every SAP. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 30	557	437	479	93	526	231	537	549
13	The individual's SAPs are complete.	0% 0/25	0/2 12/20	0/3 16/29	0/3 23/30	0/2 6/18	0/3 17/30	0/3 20/30	0/3 14/30	0/3 16/30	0/3 10/30

Comments:
13. Although none of the SAPs were considered complete, task analyses were present in every SAP where these were appropriate, operational definitions were found in the majority of the SAPs, and plans for maintenance and generalization were identified in all, but one, SAP.

Missing from the majority of SAPs were specific instructions that would ensure consistent implementation, schedules that specified the number of trials when appropriate, adequate instructions following incorrect responding, and identification of the current step in the documentation section.

In some cases, the discriminative stimulus was specific to the current step and did not address the broader or terminal skill. As written, this would require a new instruction each time the individual acquires one step of the chain. This could result in the individual waiting for each verbal instruction to complete what should be a smooth chain of behavior.

In other cases, the discriminative stimulus was a verbal instruction, however, the individual had an identified hearing loss and responded more readily when signs or gestures were used in combination with verbal instructions.

For several individuals, praise alone was the identified reinforcer for correct responding. Based upon observations conducted during the onsite visit, it is questionable whether praise from any staff member would function as a reinforcer.

Outcome 5- SAPs are implemented with integrity.

Summary: It was good to see SAPs being implemented and that some components were being done correctly. However, aspects of each SAP were not implemented as per the written plan. This contributes to lack of progress and to potential confusion for the individual. As SAPs improve in quality and content, it will be important to ensure they are written correctly. Given that Abilene SSLC already had a system to regularly observe SAP implementation integrity, this should be possible for the Center to achieve. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
14	SAPs are implemented as written.	0% 0/7	0/1	0/1	0/1	0/1	Attempted	0/1	0/1	0/1	Attempted
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.	84% 21/25	1/2	3/3	2/3	1/2	3/3	3/3	3/3	3/3	2/3

Comments:

14. The Monitoring Team was able to observe SAP implementation for seven individuals. Six of these observations were of SAPs that were part of the set of 25 reviewed SAPs. The seventh SAP had just been developed and introduced for Individual #537. For the two other individuals, Individual #93 became upset when her SAP was scheduled for observation, and Individual #549 chose to transition with her staff member to the habilitation therapy department when her SAP observation was scheduled. Observations are summarized below.

- Individual #30: The staff member implemented the SAP as written with the exception of the discriminative stimulus. Instead

of telling her to wash her hands, the staff member initiated the SAP by asking, "Hey, Individual #30, can we wash our hands?" When Individual #30 did not respond, she appropriately repeated the instruction while simultaneously signing. All other components were followed as written.

- Individual #557: The staff member did offer two different locations in which Individual #557 could complete the SAP. The staff member then asked Individual #557 if he was ready to complete his work. He then handed Individual #557 a pencil and a sheet of riddles out of his I-Book. Individual #557 then read three passages silently and filled in the missing information following each passage. The riddles were not discussed and there was no evidence of the use of a punch card following correct responding. As one of these riddles can be repeated over time, the Monitoring Team and staff discussed different options for teaching and assessing reading comprehension. One suggestion was to identify high interest/low level reading materials, which can be readily found on the Internet or may be identified by the local special education department.
- Individual #437: The staff member asked him what he was going to do in the afternoon. The schedule board was affixed to the wall and the staff member tried to show him a variety of photos/icons. The discriminative stimulus was not delivered as written and the morning was almost over (current step). The staff member did provide praise, and after a few minutes delay, offered a choice from the home reinforcement box. While discussing this with staff, it became clear that this SAP was designed to gain Individual #437's compliance in participating in activities that he requests. He can readily tell staff what he would like to do, but often does not follow through once he is in the identified environment.
- Individual #479: Individual #479 was on his way out of the home when staff presented the cards. The staff member presented the cards and provided verbal instructions, but required a prompt from BHS staff to praise the individual.
- Individual #526: Although the staff member demonstrated a very supportive interaction style with Individual #526, he did not deliver the Sd as indicated in the SAP. Instead of stating, "Brush your teeth," he said, "We're going to brush the right (side/quadrant)." He did prompt Individual #526 through the entire chain, and while an appropriate teaching strategy, this was not indicated in the SAP.
- Individual #231: The staff member gave Individual #231 a card to read while saying: "You know what to do, read the card and tell me whether it's an emergency." This was not the identified Sd in the SAP. Individual #231 identified the situation as an emergency and then stated that she would call the nurse. She required additional prompting to add that she would call 411. This did not match the SAP as written.
- Individual #537: A newly introduced SAP, the goal of which was to teach the individual to request a drink, was observed. The staff member carried out the action after Individual #537 approached the device located on the wall outside of the dining room. While enhancing his communication skills was functional and meaningful, revisions to the SAP are recommended. First, the current discriminative stimulus was "push the button." This was not related to getting a drink. Further, the button was located outside of the kitchen and access to the drink was quite delayed. It would be advisable to probe Individual #537's use of a personal communication device so that he can ask for items at any time of the day.

15. Per state policy, SAP integrity should be assessed at a minimum of twice annually. Based upon the documentation provided, it was determined that 21 of the 25 SAPs had been monitored at least once over the six-month period prior to the onsite visit. The exceptions were the following: Individual #30 - apply lotion, Individual #437 - print name, Individual #479 - pedestrian safety, and Individual #549 - letter.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: Abilene SSLC has had high performance scores on these two indicators for this review and the previous three reviews, too. Therefore, indicators 16 and 17 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
16	There is evidence that SAPs are reviewed monthly.	96% 24/25	2/2	3/3	3/3	2/2	3/3	3/3	3/3	3/3	2/3
17	SAP outcomes are graphed.	100% 25/25	2/2	3/3	3/3	2/2	3/3	3/3	3/3	3/3	3/3
Comments: 16. There was evidence that 24 of the 25 SAPs had been reviewed monthly in the individual's QIDP monthly report. The exception was the dressing SAP (put on shirt) for Individual #549. 17. Graphs were available for all of the 25 SAPs.											

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: The number of individuals observed to be engaged by the Monitoring Team (indicator 18) and the number observed to be engaged by the Center (indicator 21) were higher than at the last review. Abilene SSLC regularly measured engagement, demonstrated now for three consecutive reviews. Therefore, indicator 19 will be moved to the category of requiring less oversight. Indicators 18 and 21 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
18	The individual is meaningfully engaged in residential and treatment sites.	44% 4/9	1/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	67% 6/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1
Comments: 18. During the onsite visit, all nine individuals were observed in their homes. Additionally, four of the individuals were observed at one of their day program sites. These were Individual #30, Individual #93, Individual #231, and Individual #549. Individual #557 attended											

school during the day and did not have any time scheduled in on-campus day programs; Individual #437 was restricted to his home due to an injury; and lastly, Individual #479, Individual #526, and Individual #537 did not regularly attend day programs.

Based on these observations, it was determined that four individuals (Individual #30, Individual #557, Individual #93, Individual #231) were meaningfully engaged for most of their day. That being said, most of the individuals (i.e., all but Individual #557 and Individual #93) had little, if any, time scheduled outside of their homes. For instance, Individual #526 and Individual #537 were not scheduled to attend any day programs (although it was commendable that staff had introduced a shaping program to encourage Individual #537 to go to the activity center). Schedules for the remaining five individuals indicated between 4.5 hours to 7.5 hours of work per week. Four of these five individuals had between 3 and 19 additional hours scheduled to attend some type of day program. Individual #479 did not have any scheduled time in a day program.

There were some very positive interactions between staff and individuals that were observed by the Monitoring Team and are worthy of note.

- Individual #537 came out of his room to sit in a recliner in the living room. He was wearing socks and shoes, but once seated, he removed his shoes. The home manager was quick to respond and simply asked Individual #537 to hand him the shoes. Individual #537 complied. A short time later, a direct support professional approached Individual #537 to try to encourage him to go to the activity center. Although she helped Individual #537 put on one shoe, she then asked him to put on the second shoe. She made sure the shoelaces were untied. Individual #537 complied and was praised for his efforts.
- Another example of good engagement, with components of self-management, was Individual #280 at workshop. After folding a towel, Individual #280 moved a marker on a number line until he had folded 10 towels. He could then alert staff by ringing a bell located on his tabletop. Staff explained that this had been put in place due to his placing so many folded towels in a stack that the stack fell over. This was an excellent example of teaching the individual to manage his own work production.
- During one visit to the workshop, Individual #93 was seated across from Individual #280 as they enjoyed snack. On occasion, they communicated with each other via sign language. As Individual #93 reportedly liked Individual #280, it might be beneficial to introduce some peer tutoring activities to help expand their social and communication skills.

19. The facility had established a system of assessing engagement once monthly in each home and day program site. Engagement goals were established for all settings, ranging from 45% to 90% for homes, 50% to 80% for activity centers, 50% for senior centers, and 90% for work centers.

21. For six of the nine individuals, engagement goals were achieved in their homes and day program sites. The exceptions were Individual #479, Individual #537, and Individual #549.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30	557	437	479	93	526	231	537	549
22	For the individual, goal frequencies of community recreational	67%	0/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1

	activities are established and achieved.	6/9									
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22. Eight of the nine individuals had a goal frequency for community recreational activities identified in their ISPs. The exception was Individual #526. The goal was achieved or exceeded for six of the eight individuals (Individual #557, Individual #437, Individual #479, Individual #93, Individual #537, Individual #549).

23. There was evidence of SAP training in the community for Individual #93, but not at the established frequency.

24. There was no evidence that the IDT for any of the nine individuals had met to discuss barriers to community recreational activities and/or community-based SAP training.

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	30	93	199	82	187	145	552	178	185
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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 measurable goal(s)/objective(s);	N/A									
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 d. Although Tier I documentation indicated that Individual #185 refused dental services, it was not a true refusal. On 4/18/18, he was upset about something that happened prior to arriving at the Dental Clinic, and he would not calm down enough to cooperate with dental procedures.

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: Individuals reviewed did not have clinically relevant, and measurable goals/objectives to address their needs for formal communication services and supports. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #185's to choose between two activities. c. through e. For the nine individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.											

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: To move forward, QIDPs and SLPs should work together to make sure QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs, and when they are not implemented consistently, IDTs need to take action. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	30	93	199	82	187	145	552	178	185
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/A	N/A	N/A	N/A	0/1

b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A										
	Comments: a. As indicated in the 2018 communication update for Individual #185, the AAC device often was not available, and programs were not consistently run.											

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 focus on ensuring individuals have their AAC devices with them. In addition, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]			Individuals:								
#	Indicator	Overall Score	138	140	122	73	223	185	415	484	93
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	25% 3/12	0/1	0/1	0/1	0/1	0/1	0/1	1/2	0/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	17% 2/12	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	1/1
			Individuals:								
#	Indicator		541	312							
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.1/1		0/1	1/1							
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							
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.	0% 0/3									
	Comments: a. and b. It was concerning that often individuals' AAC devices were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.										

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

This Domain contains five outcomes and 20 underlying indicators. At the time of the last review, one indicator moved to the category requiring less oversight. At this time, no additional indicators will move 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 Center continued to use a system for provider staff training that included: 1) Center disciplines trained designated provider staff to competency in required supports: 2) these staff, in turn, trained the remaining provider staff at the home and day program; and 3) a designated Center staff completed a competency check, comprised of verbal and demonstration responses, of the home and day program provider staff after their training had been completed and before transition took place. Although more refinement of the competency criteria was needed, this was a positive practice. Although progress continued, a number of essential supports were missing from the CLDPs reviewed, and this should continue to be a focus for Center staff.

Although some work was still needed, overall, post-move monitoring was a strength at Abilene SSLC. With continued focus on the details related to correct scoring of the presence of supports, and follow-up activities, the Center's scores in this area should continue to improve.

Neither individual had experienced a PDCT event. It was notable that transition staff attributed this in large part to the improvements the Center had made in the development of measurable supports and in the comprehensiveness of pre-move training.

Transition assessments did not consistently meet criterion, but the Center had implemented some improved processes. For example, transition staff developed training materials for staff conducting assessments, and transition staff persistently followed up to obtain clarifications and additional information from assessors. Transition staff should continue to pursue these strategies, with the expectation that discipline assessment practices will improve over time. During this review and the last one, documentation was present to show involvement of IDT members, including the individuals and their family members/guardians in the transition process, as well as identification of IDT members' responsibilities in the CLDPs. If the Center sustains this progress, after the next review, Indicator 13 might move to the category requiring less oversight. Similarly, after the next review, Indicator #18 might move to the category requiring less oversight, if transition staff continue their collaborative efforts with Local Authority staff. Work is still needed with regard to IDTs' decision-making regarding the need for

Center clinicians to collaborate with community clinicians, the conduct of setting assessments, and considerations for the involvement of direct support staff in transition activities.

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: The Center continued to use a system for provider staff training that included: 1) Center disciplines trained designated provider staff to competency in required supports: 2) these staff, in turn, trained the remaining provider staff at the home and day program; and 3) a designated Center staff completed a competency check, comprised of verbal and demonstration responses, of the home and day program provider staff after their training had been completed and before transition took place. Although more refinement of the competency criteria was needed, this was a positive practice. Although progress continued, a number of essential supports were missing from the CLDPs reviewed, and this should continue to be a focus for Center staff. These indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	488	354								
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: Since the last review, three individuals transitioned from the Center to the community. Two were included in this review (i.e., Individual #488 and Individual #354). Both individuals transitioned to community group homes. The Monitoring Team reviewed these two transitions and discussed them in detail with the Abilene SSLC Admissions and Placement staff.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. Overall, the IDTs had made substantial progress in identifying the measurable criteria upon which the Post-Move Monitor (PMM) could accurately judge implementation of each support, but still needed some additional refinement overall. Examples are described below:

- Pre-move supports: At the time of the last monitoring visit, the Center had begun to use a system for provider staff training that included three primary steps: first, the appropriate Center disciplines would train designated provider staff to competency in required supports. These staff, in turn, would then act as trainers for the remaining provider staff at the home and day program. Finally, a designated Center staff would complete a competency check, comprised of verbal and demonstration responses, of the home and day program provider staff after their training had been completed and before transition took place. Since that time, the Center had continued to use this model for pre-move provider staff training, with increasing success. Findings included:

- The IDT for Individual #488 developed six pre-move training supports in the areas of medical/nursing needs and habilitation supports, while the IDT for Individual #354 developed nine pre-move training supports in the areas of medical/nursing, habilitation, and behavioral needs.
- As written in the CLDP, the pre-move training supports specified the staff to be trained as well as who would provide the training and described the type of training and the type of competency testing that would be administered at each stage of the three-step training process. It was good to see the Center often required more than just a written test, frequently also requiring demonstration.
- For purposes of measurability, the Center still needed to ensure the supports described competency criteria that were comprehensive, and clearly stated and defined an appropriate testing methodology. As written in the CLDP, the pre-move training supports often did not specify the competency criteria. In some instances, however, the training and competency materials provided for review (i.e. for nursing supports) included detailed checklists that indicated the specific competencies staff should demonstrate and indicated what form of competency demonstration was required. It would be appropriate, for the sake of brevity, for the pre-move training supports to refer to these checklists for description of required competencies.

- Post-Move: The respective IDTs developed 43 post-move supports for Individual #488 and 47 post-move supports for Individual #354. To achieve compliance, IDTs need to describe the required evidence that would provide the PMM with clear measurable indicators. The post-move supports for both individuals frequently met this standard. Overall, the IDT for Individual #354 developed measurable post-move supports, but again some additional refinements for Individual #488's were still needed. Findings included, but were not limited to:
  - On a positive note, the pre-move training supports for both individuals consistently had corresponding post-move supports for staff knowledge, and these often were more measurable as stand-alone supports than the pre-move versions. This provided a mechanism for measuring staff knowledge of important needs on an ongoing basis, even after the pre-move support had been satisfied.
  - For Individual #488, the CLDP included a support that called for the provider to complete an assessment of her needs for skill acquisition and implement formal training within 90 days. This was overly broad and did not provide the PMM with criteria for confirming if the support was in place. For example, it was unknown whether training should occur on a daily, weekly or monthly basis.

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. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. Still, neither of these CLDPs fully and comprehensively addressed support needs and did not meet criterion, as described below.

a. Past history, and recent and current behavioral and psychiatric problems: The Monitoring Team noted substantial improvement in the development of behavioral and psychiatric supports when needed, but this was not yet consistent. Findings included:
   - Individual #488 did not have a significant history of behavioral or psychiatric needs, but had been provided with behavioral supports twice in past years to address regurgitation and pica. The Center did not address these in a clear and assertive manner.
     - The documentation indicated the former concern of regurgitation had been resolved with ongoing medical

treatment after testing revealed a physical cause. While not necessarily behavioral in nature, the IDT should have considered alerting provider staff to monitor for recurrence of this behavior as a possible indicator of a health need.

- Per the documentation related to pica, Individual #488 liked to feel dirt, grass and leaves when she was outside and had been known to end up with leaves in or near her mouth. The behavioral health assessment (BHA) indicated that after observation, this was considered to be incidental and not a purposeful placement of the material in her mouth. The IDT developed a post-move support for the opportunity to sit outside in her fenced backyard which included a statement that she liked to pick up leaves and crunch them in her hands; further, that staff could allow her to do this but assist her to wipe her hands when she was finished. The IDT should have considered a more explicit statement about her history of leaves often ending up near or in her mouth so that community provider staff could monitor her closely while she was engaged in this preferred activity.
- Per the ISP, the IDT knew Individual #488 might attempt to bite or hit providers during dental procedures. Also, per the nursing assessment, direct support staff could not brush her teeth effectively due to her behavior. Finally, the QIDP monthly reviews documented that some dental treatments (e.g., scaling) could not be completed due to behaviors. This would be important information to transmit to the provider and the community dental provider so that they could be prepared to provide needed supports for dental care, but the IDT did not develop any supports to ensure this provider staff knowledge.

In its comments on the draft report, the State disputed the first two sentences of this finding and stated: "In the Nursing Assessment provided in **TX-AB-1811-I.66.A, on page 20** there is a summary of the dentist's report concerning a dental visit on 03-30-2017 that reads: 'Per DSP present they cannot brush effectively twice a day due to behavior.' However, at later visits documented in the Nursing Assessment there is no mention of difficulty helping #488 with daily oral hygiene. For example; On pgs. 22&23, at the 09-15-17 consult visit it was noted that 'patient is brushed regularly at home.' This supports what was learned during the CLDP process as well as what is documented in the discussion of dental risk from the IRRF on pages 28-29 of the document request. Individual #488 is compliant with daily oral care and some dental office procedures but must be sedated for deep scale root planning and other invasive dental procedures. Pre-move supports #4, 5, and 6 **(TX-AB-1811-I.67.A, pages 35-36)** addressed use of the vacuum toothbrush. Post-move support #9 (page 38) addressed staff assisting #488 brushing teeth twice daily with the vacuum toothbrush and flavored toothpaste. Post-move support #37 (page 47) called for the provider to locate a dentist that offers sedation dentistry to provide care. No additional behavior supports were needed to address difficulty during daily toothbrushing because #488 complies with staff assistance."

It is important to understand the context of this finding, which illustrated a concern related to her past history as well as recent behavioral problems and the importance of sharing this history with providers. The CLDP did not provide supports to communicate this knowledge of her history. The State's comments confirm this history, dated 3/3/17. The ISP, dated 7/12/17, provided additional documentation on page 19, noting she required chemical and physical restraint for dental appointments, and one-to-one level of supervision, due to

the following behaviors:

- Grabs provider's hands during dental procedures stopping dental procedures;
- Twists heads during dental procedures impeding delivery of dental care;
- Attempts to bite and/or hit providers during dental procedures; and
- Extreme anxiety for dental appointments.

Her IRRF at the time also indicated she required oral sedation for dental care because of behaviors. This would indicate the behaviors were of a nature and recency that a support for provider knowledge would be in order.

- For Individual #354, the IDT developed detailed post-move supports related to current behavioral/psychiatric needs as well as related history. These addressed prevention and strategies to address aggression, elopement, self-injurious-behavior, pica, and property destruction. In addition, supports described how to implement teaching of functional replacement behaviors and historical behaviors to monitor. This was positive overall, but some remaining significant concerns included:
  - The supports did not describe his known history of inappropriate sexual behavior or related prevention and intervention strategies.
  - The IDT developed a support for responding to elopement, but also developed a supervision support that was not consistent with this behavior. The supervision support indicated that when he was inside his home or the day program, provider staff should know where he was, but did not have to have him in their sight at all times. The IDT did not provide a clear rationale for this level of supervision: documentation indicated he had one-to-one staff at the Center until shortly before transition due to a long history of leaving an area without proper escort. Per his ISP, which was held on 7/18/18, less than 30 days before transition, the IDT had tried a number of times to reduce the level of supervision without success. Specifically, it stated anytime the IDT had tried to reduce his level of supervision, he left the campus and put himself at risk crossing the street. The Monitoring Team discussed this with transition staff while on-site, who indicated the IDT told them that the ISP information was erroneous. Following the monitoring visit, the Center provided ISPA documentation from May 2018 that indicated Individual #354 required "enhanced" supervision rather than one-to-one staffing, while reiterating his long history of elopement. The documentation still did not fully clarify why he did not need at least line-of-sight supervision, particularly as he adjusted to a new environment and staff, or explain the lack of a support for provider knowledge of his history in this regard.
  - It was concerning the CLDP characterized Individual #354's sleep disturbance as a "historical" behavior to be monitored, since his transition had been delayed by an ongoing episode of sleep disturbance associated with manic behaviors and significant aggression and property destruction. Per the behavioral health transition assessment, the provider needed to have a response plan for psychiatric instability to provide for safety and additional staffing during times of mania, which might be demonstrated by wandering and walking off during the day and/or night and property destruction. The IDT only minimally addressed this in a support for historical behaviors, which included one instruction to call for additional staff if at bedtime, he was engaging in manic behaviors. This support was not assertive or comprehensive given the recent nature and severity of those behaviors.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. To meet

criteria, the IDTs still needed to develop clear and comprehensive supports in these areas. Findings included:

- Neither CLDP indicated the level of nursing oversight needed for these individuals.
- Other examples of needed improvement for Individual #488 included, but were not limited to:
    - Per the nursing assessment, Individual #488 had fragile bones precautions, but the CLDP did not include any specific supports for staff knowledge or competence in this area.
    - The IDT did not clearly state or fully emphasize her risk for falls. The Integrated Risk Rating Form (IRRF) review in the CLDP did not contain accurate information, indicating that her assessed high risk for falls had been due to a fall with serious injury a year before, but that she had not had any falls or injuries during the past year. As a result, the IDT agreed the risk was no longer as significant. This assessment did not take into account falls data from the nursing assessment or from the QIDP monthly reviews that documented between six to nine falls within the last 12 months and as recently as February and March of 2018.
    - In what was possibly a related concern as it pertained to her risk for falls, in March and April 2018, Individual #488 had experienced episodes of hypotension. The IDT failed to document they had completed the recommended follow-up prior to the transition and did not include any related staff knowledge or follow-up requirements in the CLDP supports.
- Other examples for Individual #354 included, but were not limited to:
    - Per the habilitation assessment, he had supports to meet his sensory needs including a porch swing/glider/rocking chair for vestibular input and techniques for engaging in heavy work activities such as moving chairs and tables, pushing rolling carts, wall push-ups, and using the trampoline to provide proprioceptive input which, in turn, would help calm him. The CLDP included a single pre-move support for having a porch swing or glider so that he could sit outside, but did not describe the sensory purpose or require any staff knowledge of his sensory needs overall.
    - Per the communication assessment, the IDT had requested a picture schedule be developed for Individual #354. The assessment indicated he had the ability to benefit from this and that a picture schedule would be appropriate, but recommended deferring this to the community so that the pictures would be relevant in his new home. The IDT did not develop any supports related to the picture schedule.
    - The CLDP did not address Individual #354's risks of weight gain and metabolic disorder in an assertive manner. Per the medical assessment, the primary care practitioner (PCP) recommended the risk level in the IRRF be raised to high; further, the assessment recommended referral to physical therapy (PT) for a formal exercise regimen and for the IDT to meet to consider weight loss options, including medication. The annual PT assessment indicated disagreement about the need for a formal exercise regimen, and went on to recommend that if the PCP wanted Individual #354 to lose weight, the IDT might want to consider enrolling him in a gym or dance class in the community as a formal exercise regimen. The CLDP narrative indicated that weight loss supports would be included in the nursing and nutrition sections, but neither addressed any exercise regimen. The CLDP included a post-move support for a weight reduction diet, but none for exercise, formal or otherwise, to promote weight loss.

c. What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. While both CLDPs did address some outcomes important to each individual, neither CLDP did so

assertively. Examples included:

- The CLDP for Individual #488 indicated her important outcomes were more contact with her mother and other family members; being able to be outdoors and participate in outdoor community outings; and, maintaining good health. Per her ISP, PSI and assessments, she also had other important preferences the IDT did not address with supports. For example, per her ISP and several assessments, Individual #488 had a special friend with whom she spent time. The IDT did not create any supports to either continue this relationship or otherwise create opportunities for generating new friendships.

  In its comments on the draft report, the State disputed the last two sentences of this finding and stated: "The 'special friend' was a staff at the Activity Center who #488 showed a preference for and was not someone that she had a relationship with outside of the Activity Center. As stated in the CLDP **(TX-AB-1811.I.67.A, page 32**), the most important thing to #488 is spending time with her mother. No other relationships were identified by the IDT as being important to her. Post-move supports #1 & 2 (page 37) addressed maintaining contact with the mother and continuing this relationship."

  Individual #488's ISP referenced her special relationship with her friend on several occasions, including during the discussion of her relationships, stating the relationship was "very important" to her. It further noted her special friend attended her ISP meeting, which made her very happy. Her prioritized preferences in her Preferences and Strengths Inventory (PSI) included spending time with her special friend. Based on that documentation, the IDT should have identified this as an important relationship. The IDT should have also then considered if the relationship could be sustained in some way, or otherwise considered how to give her an opportunity to have a friend she could see regularly, especially since the mother's visits were periodic, even after the transition.
- The CLDP for Individual #354 identified important outcomes as living closer to his grandmother and other family and being able to visit regularly; losing weight to improve overall health; and, making new friends with peers and staff at home and day program. The IDT included post-move supports for calling his grandmother, but did not prescribe an assertive role for the provider in facilitating more frequent visits. Similarly, the IDT did not include assertive supports for losing weight, focusing on diet only, but providing no supports for exercise. The IDT did not include any action plans for making new friends. Per his ISP, he had an action plan to initiate games that could be played with a peer, but the IDT determined no support would be needed because this would happen "naturally." Without a support to track it, no data were available to evaluate whether any games were played or friendships established. The IDT needed to have developed more assertive supports that provided sufficient opportunities to achieve important outcomes.

d. Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion:
   - For Individual #488, the IDT developed a post-move support for attending a day program, but offered little in the way of recommendations for meaningful activities in integrated community activities.
   - Individual #354 was a young man who had just recently graduated from high school. The IDT did not complete a vocational assessment of his preferences, strengths, and needs regarding employment; rather, it indicated only that he was not interested in work. This did not provide documentation of any vocational exploration that might have been attempted. The CLDP also did not include any supports for meaningful activities in an integrated setting. This could have been a good opportunity to develop a support for enrolling in a dance class or gym, as the habilitation therapy

assessment had recommended.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success:
   - For Individual #488, the CLDP did include post-move supports for the opportunity to have increased contact with her mother, which was positive. In addition, post-move supports addressed communication strategies and engaging in specific preferred activities at the day program and community outings. It was concerning, though, that the IDT did not address opportunities to fill the gap left by the loss of contact with her special friend, by all accounts an important support in her life.
   - The IDT for Individual #354 developed several behavioral supports for reinforcement and motivating components, which was positive; however, the IDT did not integrate important sensory supports as described above. In addition, the CLDP included few supports for community participation and integration, limited to going out to eat at least once every three months and attending movies twice over the next year. This was a minimalist view of an active leisure life, in general, but was especially concerning because his behavioral strategies emphasized that he needed to stay engaged and not get bored.

f. Teaching, maintenance, participation, and acquisition of specific skills: The IDTs did not provide assertive supports in this area. Examples included, but were not limited to:
   - Individual #488's functional skills assessment (FSA) indicated she could learn to take her dishes to the sink after she finished with meals or snacks, and noted needs for skill development in the areas of bathing and pedestrian safety. The FSA also identified future training needs for handwashing and making a purchase. The IDT addressed these needs in a broad manner only, calling for the provider to complete an assessment of her needs in her new home and implement formal skill acquisition within 90 days. It was positive the CLDP included an outcome expectation for skill acquisition in the future, but needed to provide some measurable specificity, particularly because the IDT already knew that she had needs in certain areas. While there is some value in allowing the provider to assess an individual's needs in a new setting, supports for known needs could begin at transition and newly-identified needs still could be added at the end of 90 days.
   - Individual #354's CLDP did not address his assessed needs for skill acquisition needs in an assertive manner. It included a post-move support for dialing his grandmother's phone number and brushing his teeth twice a day. But per his FSA, he had many other needs. These included, for example, naming objects in the community; following one-step and first-then directions; pointing to and naming body parts; answering yes/no questions; initiating social greetings and responding to conversation started by others; keeping a comfortable distance between self and others; inviting others to engage in leisure activities; giving simple directions to others; following a structured game or activity; choosing between two items or activities; washing hands; communicating the need to toilet, when necessary; locating public restrooms; knowing coins and bills; using a bank account; making a bed; sweeping; vacuuming; laundry; and meal preparation. All of these would have been appropriate options for skill development in the community and might have indicated a need for ongoing communication therapy. He also had a specific, known need for learning pedestrian safety skills, given his history of elopement and putting himself at risk when crossing the street. This risk was potentially amplified by the decision of the IDT to not require line-of-sight supervision, as described earlier.

g. All recommendations from assessments are included, or if not, there is a rationale provided: Abilene SSLC had a process in place for documenting in the CLDP the team's discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional recommendations. Still, for both individuals included in this review, the IDTs did not address

all recommendations with supports or otherwise provide a justification, as described further below.

In its comments on the draft report, the State requested clarification and stated: "Monitors used the word 'assertive' throughout this section of this report (10 times) to describe supports… What does assertive mean in the context used? How can it be measured? Original language of the Settlement Agreement for MIS states that supports are to be measurable. If we are going to be held accountable for being assertive then we need to know what that means in relation to supports." The Lead Monitor reviewed the uses of the word "assertive," and in each instance, in the narrative before and/or after the word, the Monitoring Team clearly defined the concerns, and described the changes IDTs needed to make to ensure that IDTs "identify… the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs," as per the Settlement Agreement. In other words, IDTs need to develop sufficient supports to ensure safety and provide adequate habilitation, and in many cases, IDTs had not fulfilled this requirement. In none of these instances was the word used to define "measurability" of supports.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.

Summary: Although some work was still needed, overall, post-move monitoring was a strength at Abilene SSLC. With continued focus on the details related to correct scoring of the presence of supports, and follow-up activities, the Center's scores in this area should continue to improve. At this time, these indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	488	354							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	50% 1/2	0/1	1/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's scoring is correct based on the evidence.	50% 1/2	0/1	1/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	50% 1/2	0/1	1/1							
8	Every problem was followed through to resolution.	50%	0/1	1/1							

		1/2									
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	N/A							

Comments: 4. In many cases, the PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports. The PMM consistently provided substantial comments. These typically addressed the required evidence. It was sometimes not possible to ascertain whether reliable and valid data were present due to a lack of specificity and measurability of some supports as described with regard to Indicator #1. Overall, however, the PMM collected reliable and valid data for Individual #354, whose post-move supports did provide the needed specificity. Concerns for Individual #488 included, but were not limited to:

- For Individual #488, a support for her shower chair did not specify the requirement for her feet to be on the floor or otherwise braced, and the PMM did not document interviewing provider staff regarding this knowledge.
- The PMM marked a post-move support for assisting Individual #488 with toileting as in place, but the data provided did not indicate whether provider staff checked and assisted her for toileting every two hours as required. In its comments on the draft report, the State disputed this finding, and stated: "#488 does not have a requirement that staff check her every 2 hours as she will indicate when she needs to toilet. Post-move support #5 **(TX-AB-1811-I.67.A, page 37)** addresses monitoring bowel movements daily and support #25 (page 43) addresses providing assistance with toileting. No data is required for staff assisting her every two hours." The context of this bullet is important. The complete finding was that it was sometimes not possible to ascertain whether reliable and valid data were present due to a lack of specificity and measurability of some supports as described with regard to Indicator #1. This support was provided as an example of this concern. It called for staff to provide assistance daily with toileting, bathing, grooming and dressing. Individual #488's IRRF indicated direct support professional staff should assist her with personal hygiene every two hours and more often as needed. The support did not integrate this need in a measurable way, but should have. Because the support was insufficient, the PMM was unable to ensure it was implemented as it needed to be.

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP, but this was not yet consistent. As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack clarity and measurability in the supports as written. Examples of important supports not in place as required included the following:

- For both individuals, the PMM found a number of supports were not in place because the day program was not completing the required checklist. It was positive the PMM documented testing staff knowledge of these supports, through interview and observation, but the available evidence did not substantiate that the supports had been routinely carried out as required.
- For Individual #488, some important health care supports, such as bowel tracking, bowel management, and use of mealtime adaptive equipment were not in place.
- For Individual #354:
    - The provider had not implemented his weight-reduction diet as required at the time of the seven-day PMM visit. The PMM observed that the day program snack sent from home was a doughnut bar, which was not appropriate to his diet. The day program also did not have the required checklist. This continued to be an area of concern at the time of the

45-day PMM visit, when the PMM witnessed a day program staff provide Individual #354 with a whole granola bar rather than his required chopped texture.
  - At the time of the 45-day PMM visit, the provider had not implemented the supports to call his grandmother at least weekly.
  - At the time of the 45-day PMM visit, the PMM discovered through her review of the medication administration record (MAR) that Individual #354 had not been receiving Depakote as prescribed due to a dispensing error. It was unclear why provider staff, who had received training on his medications, would not have realized the discrepancy, but it was positive that the PMM followed up to ensure re-training of staff.

6. The Post-Move Monitor's scoring was generally correct, based on the supports defined in the CLDP, with some exceptions for Individual #488:

- For Individual #488, in addition to examples described with regard to Indicators 4 and 5 above:
  - At the time of the 45-day PMM visit, the community PCP decided to discontinue pap smears. Per the post-move support, the IDT required that a sufficient rationale be provide in the event such a decision was made. The only rationale provided was that pap smears were unnecessary "due to her current status." The PMM marked this support as in place, but the rationale provided was insufficient.
- For Individual #354, the PMM's scoring was generally correct overall.

7. through 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. As reported at the time of the last monitoring visit, the PMM was extremely diligent in following up to ensure corrective actions were implemented in a timely manner once a need was identified. It was also positive the IDTs met to review the PMM Checklists and make recommendations for any unmet supports, and that the PMM documented the required follow-up had been completed. The Monitoring Team again found this to be an area of strength in the Center's transition processes. For Individual #354, follow-up had been completed as required. Some additional improvement was needed for Individual #488, including:

- At the time of Individual #488's 90-day PMM visit, the provider had not yet assessed for, or put into place, formal skill training as required. The PMM marked this as not applicable because the PMM visit took place at approximately 81 days after transition rather than 90. Under those circumstances, if a support was not marked for follow-up, it would not be assessed again until the 180-day PMM visit, which would be an inordinate delay. Given the importance of formal skill training, it would have been reasonable for the PMM to mark this for follow-up, and complete follow-up at the 90-day mark.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.												
Summary: Neither individual had experienced a PDCT event. It was notable that transition staff attributed this in large part to the improvements the Center had made in the development of measurable supports and in the comprehensiveness of pre-move training.			Individuals:									
#	Indicator	Overall Score	488	354								

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.	100% 2/2	1/1	1/1							

Comments: 11. Neither individual had experienced a PDCT event. It was notable that transition staff attributed this in large part to the improvements the Center had made in the development of measurable supports and in the comprehensiveness of pre-move training. Although the Monitoring Team agrees that the additional measurable supports and improvements with regard to pre-move training were steps in the right direction, as discussed above, Center staff still needed to improve in those areas to increase the likelihood that no PDCTs would occur. For example, the fact that Individual #354 did not receive his medication with a psychotropic purpose for an extended period could easily have resulted in a PDCT, particularly since he did experience some behavioral episodes during that time. A PDCT did not occur, but that was largely a matter of happenstance; it still should have prompted the Center and the IDT to evaluate the effectiveness of their pre-move training in this area.

In its comments on the draft report, the State disputed the last two sentences of this finding and stated: "This was determined to be due to a pharmacy error as well as a nursing error. The community pharmacy did not include a medication when printing off the MAR for the month. The community nurse did not follow the company's protocol and did not check the MAR as required before sending it out to the home. Staff were administering medications as instructed on the MAR. The PMM found the error at the 45-day visit and immediately pointed it out. The provider had it corrected and a new MAR sent to the home that same day. The medication was started again and follow-up with medication levels was requested and completed. The provider retrained all of its nurses and added a step in their process for reviewing MARs prior to sending them to the homes. This was ongoing after the visit and was all documented as follow-up in the 90-day PMM report. During the on-site interview with the monitoring team members it was discussed that this had all occurred and documentation was in the 90 day [sic] report. The monitors did not request the 90-day PMM report for #354. The report would have shown the documentation for all of the continued follow-up. This was an error caused by a nurse not following the company's set procedures. There is no training that AbSSLC could have provided that would have prevented this. The center would be happy to provide this additional information."

The Monitoring Team recalls this discussion during the on-site visit and appreciated and commended the follow-up of the transition staff regarding this concern, once it was discovered. This context of this comment had to do with the potential for negative events (PDCTs) to occur. This episode thankfully did not result in a PDCT, but could well have because Individual #354 was without his psychotropic medication for a lengthy period of time. During that time, the individual had at least two documented behavioral episodes. Per the 45-day PMM documentation, on 9/24/18, this medication had been left off the September MAR and the provider nursing staff failed to recognize it was missing until the Post-Move Monitor detected it. This called into question not only the provider's processes, but should have prompted the Center to consider whether its training had resulted in adequate retention of key information. The training covered medications; so, if adequate, the provider nurse might have been expected to be able to identify that one of his key medications was missing. One of the most important facets of the PDCT review process is to critically analyze what may be improved for the future. That should also be true for significant medication errors such as this one.

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: Transition assessments did not consistently meet criterion, but the Center had implemented some improved processes. For example, transition staff developed training materials for staff conducting assessments, and transition staff persistently followed up to obtain clarifications and additional information from assessors. Transition staff should continue to pursue these strategies, with the expectation that discipline assessment practices will improve over time. During this review and the last one, documentation was present to show involvement of IDT members, including the individuals and their family members/guardians in the transition process, as well as identification of IDT members' responsibilities in the CLDPs. If the Center sustains this progress, after the next review, Indicator 13 might move to the category requiring less oversight. Similarly, after the next review, Indicator #18 might move to the category requiring less oversight, if transition staff continue their collaborative efforts with Local Authority staff. Work is still needed with regard to IDTs' decision-making regarding the need for Center clinicians to collaborate with community clinicians, the conduct of setting assessments, and considerations for the involvement of direct support staff in transition activities. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	488	354							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/0	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.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	50% 1/2	0/1	1/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborate with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments: 12. Assessments did not consistently meet criterion for this indicator, but the Center had implemented some improved processes. For example, transition staff had developed training materials, such as a "cheat sheet" to guide the disciplines about requirements for assessment recommendations. The Center also provided good documentation of persistent follow-up by transition staff for clarifications and additional information. Transition staff should continue to pursue these strategies, with the expectation that discipline assessment practices will improve over time. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 days of transition: Assessments provided for review met criterion for timeliness, but neither individual had a vocational assessment or update provided. In addition, the respective IDTs indicated they had reviewed the current IRRFs during the CLDP meeting, but this review did not address updated information in an adequate manner. For example:
  - For Individual #488, the IDT documented it reviewed the IRRF at the CLDP meeting and determined no updates were required and that the IRRF addressed all of the individual's needs. The IDT stated that the high risk for falls described in the IRRF was due to a fall with serious injury a year ago, but that she had not had any falls or injuries during the past year. The IDT agreed her risk in this area was no longer as significant. This was inaccurate. The IRRF reviewed did not take into account the six falls cited in the nursing transition assessment or several additional falls documented in the QIDP Monthly Reviews.
  - For Individual #354, the IDT documented it reviewed the IRRF at the CLDP meeting and found that his risk for Cardiac was rated as medium. The IDT should have addressed the PCP's recommendation that this risk be elevated to high.
- Assessments provided a summary of relevant facts of the individual's stay at the Center: Many discipline assessments provided a summary of relevant facts, but neither individual had a summary related to vocational history and/or needs. Also, as described above, Individual #488's nursing assessment did not fully describe her falls risk.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Examples of assessments that did not yet thoroughly provide recommendations to support transition included:

- For Individual #488, neither the nursing or medical assessment provided recommendations regarding her episodes of hypotension. The OT/PT assessment did not provide comprehensive recommendations for falls prevention.
- For Individual #354, the OT/PT assessment indicated he had supports to meet his sensory needs, including a porch swing/glider/rocking chair for vestibular input and techniques to give him opportunity to engage in heavy work activities, such as moving chairs and tables, pushing rolling carts, wall push-ups, and using a trampoline to provide proprioceptive input and help calm him. This was positive, but the assessment did not provide specific recommendations for the community provider to implement.

- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Currently, assessments did not consistently meet criterion in this area.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting: For both individuals, the Center maintained detailed Transition Logs. These were helpful in understanding how the Center's transition processes ensured necessary participation. Section IV of the CLDP document, entitled Community Living, also provided details of transition activities that described the involvement of the individual and LAR/ family, the LIDDA, and Center staff.

14. Center 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: This training did not yet meet criterion for these two CLDPs, as described with regard to Indicator 1 above and further described below, but substantial improvements were noted. Findings included:

- The IDTs had made substantial progress in clearly identifying the expected provider staff knowledge or competencies that needed to be demonstrated, especially in the area of medical and nursing supports. While the pre-move supports for these two individuals did not clearly specify the competency expectations, Center nursing staff had developed extensive checklists that did so. For nursing supports, the Center also used these checklists to achieve substantial progress in the delivery of training and for confirming provider staff had the knowledge and competencies to address the individuals' health and safety needs. As discussed above, for purposes of measurability, the Center still needed to ensure the supports described competency criteria that were comprehensive, and clearly stated and defined an appropriate testing methodology. It would be appropriate, for the sake of brevity, for the pre-move training supports to refer to the checklists staff were using for the description of required competencies,
- It was also positive that Individual #488's pre-move training for both habilitation and communication included some demonstration requirements for important skills such as the use of her gait belt and how to use parallel talk and object cues. Individual #354's competency testing requirements did not include any specific demonstration requirements. In some instances, his training signature sheets indicated some demonstration might have taken place, but the documentation did not provide any specific information. The Monitoring Team encouraged transition staff to ensure their training documentation was clear and comprehensive.
- While substantially improved, training and competency testing did not yet consistently cover important support needs. For

example:

- For Individual #488, competency training and testing did not adequately address staff knowledge of fragile bones precautions. For instance, the nursing training and testing referred to habilitation supports for detailed information related to her risk of falls and fractures, but the habilitation testing did not discuss fragile bone precautions.
- Individual #488 also had individualized dining techniques, but the IDT did not provide evidence that provider staff had sufficient knowledge of these. For example, one of her dining techniques was to allow her to pause periodically and rock in her dining chair to help her food move through her stomach. Without this specific instruction, it would have been likely a new staff would interpret this as an undesirable behavior.
- For Individual #354, Center behavioral staff had developed a competency demonstration check sheet, but did not provide an answer key that specified what criteria would be used to confirm those competencies. Behavioral staff might want to refer to the nursing training model as they continue to make improvements. Similarly, habilitation and communication testing protocols were improved, but were not yet comprehensive.

15. When necessary, Center staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as to whether any collaboration was needed, and if any was completed, summarize the findings and outcomes. It was positive the respective IDTs had begun to discuss and document the need for any collaboration at the 14-Day ISPA meeting, but IDTs should update these findings and recommendations at the time of the CLDP meeting and document this discussion.

- For Individual #488, the IDT determined the provider nurse and Center nurse would meet, but that no other collaboration between professional staff was needed. The IDT developed a pre-move support for this recommended collaboration. This was positive. On the other hand, per the 14-Day documentation, no habilitation staff attended the meeting, making it unlikely the IDT could have adequately considered whether collaboration in this area might have been needed. The IDT did not document such a consideration at the time of the CLDP meeting.
- At the time of his 14-Day ISPA meeting, Individual #354's IDT stated that collaboration needed would include a nurse-to-nurse meeting for medication administration and the IHCP; for the BCBA to make contact with the community counterpart prior to the move to discuss the behavior support plan; and, for the community psychiatrist to be given contact information for the Center psychiatrist to discuss as needed. The IDT developed supports for all three, but only one included a sufficiently assertive approach, as described below:
  - At the time of the CLDP, the IDT did develop a support for pre-move consultation between the nurses. This was positive.
  - The IDT also developed a post-move support for the provider nurse to share important information and recommendations from the Center psychiatrist with the community psychiatrist. This included provision of the phone number as suggested at the 14-Day ISPA, but also included specific recommendations about considerations before making medication changes, such as how to respond to brief hypomanic episodes. The IDT did not document a discussion about whether this type of communication might have been more appropriately completed in a discipline-to-discipline fashion, but should have.
  - The IDT developed a post-move support for the Center BCBA to contact the provider counterpart within 30 days after transition to review the behavior plan rather than a pre-move support as recommended at the time of the 14-day meeting. The IDT did not document a discussion about why it no longer considered a pre-move consultation to be

necessary, but should have, especially in light of the significant behavioral issues that had occurred after the 14-Day meeting and shortly before transition.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. Again, it was positive the respective IDTs had begun to discuss and document the need for any settings assessment at the 14-Day ISPA meeting, but should update these findings and recommendations at the time of the CLDP meeting and document this discussion.

- For Individual #488, the 14-Day ISPA indicated the PNMP Coordinator needed to ensure her shower chair met the specifications for use prior to her overnight visit. Otherwise, the document indicated no additional environmental modifications were needed. It was still a concern that no habilitation staff attended this meeting and participated in this determination, based on her needs.
- For Individual #354, the IDT documented a discussion that he did not require any environmental modifications to the home or day program and met criterion.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of 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 Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. Neither CLDP provided a specific description of any considerations for the involvement of direct support staff in such activities.

18. The APC and transition department staff collaborate with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition: Both CLDPs met criterion.

19. The pre-move site reviews (PMSRs) for both individuals were completed in a timely manner. It is essential the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility. It was positive the Center had made substantial progress in this area by improving its pre-move provider staff competency processes, but neither of these two PMSRs fully accomplished confirmation of provider staff competency. Even with the progress made in provider training as described above with regard to Indicator 14, these were not yet sufficient as evidence that provider staff were competent to deliver important support needs.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	488	354							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1							

Comments: 20. Both CLDPs met criterion for this indicator.

- Individual #488 was referred on 8/3/17 and transitioned on 5/1/18. This exceeded 180 days, but the Transition Log documented ongoing collaboration with the LAR, as well as community exploration and trial visits.
- Individual #354 was referred on 3/6/17 and transitioned on 8/15/18. This exceeded 180 days. The Transition Log documented some justifiable delays due to behavioral and psychiatric concerns. It was positive the documentation further indicated transition staff and the IDT remained engaged in ongoing discussion and assessment during that time and avoided any further unnecessary delay.

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