United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

Dates of Onsite Review: August 26th through 29th, 2019

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

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

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

Executive Summary

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

Through the course of this review, the Monitoring Team identified that Individual #444 had a number of needs that were not being met and that needed attention from Center staff. For instance, he had frequent seizures, some of which resulted in falls and significant injuries; different types of seizures; frequent falls with various causes; little programming; frequently was not engaged in activities; did not communicate his preferences in a way staff could consistently understand; and had worsening behavioral stability. This is detailed throughout this report, but in particular under:

- Domain #2:

    - Individual Support Plan (ISP) outcome 3, indicators 13, 14, and 15;
    - ISP outcome 5, indicator 34;
    - ISP outcome 6, indicator 36;
    - Behavioral health outcome 3, indicator 12; and
    - Behavioral health outcome 4, indicator 15.
- Domain #3:
    - Restraints outcome 7, all indicators.
- Domain #4:
    - ISP outcome 8, indicator 39;
    - Skill acquisition plans (SAPs)/engagement outcome 4, indicator 13; and
    - SAPs/engagement outcome 7, indicator 18

Individual #444 was not in the physical health team's review group. However, based on review of limited documentation, and as discussed with the Center Director and Assistant Director of Programs (ADOP) at the end of the onsite review week, his multiple falls/seizures had resulted in cuts, bruises, and head injuries, and placed him at ongoing risk of harm. The Interdisciplinary Team (IDT) and/or Physical and Nutritional Management Team (PNMT) needed to engage in in-depth analysis to identify and address the potentially multiple factors that impact his falls, as well as to ensure that as soon as possible, an epileptologist needed to assess him in relation to his seizure disorder.

The Monitoring Team members appreciated the State Office Nursing Discipline Coordinator's willingness to review the individual's record and provide some recommendations to staff while she was on site. In addition, the Monitoring Teams appreciated the Center Director and ADOP's commitment to pursue such recommendations, as well as to set up Grand Rounds to include the IDT, Center Discipline Leads, as well as, hopefully, additional State Office Discipline Coordinators. To address this individuals' needs, such a group would likely need to engage in an intense data-based review, resulting in the development of specific and integrated plans that involve improved residential, day/vocational, medical, nursing, behavioral, psychiatric, and habilitation therapy supports, treatments, and interventions.

By 12/1/19, the Monitors request an update on the status as well as the results of these activities that the Center administration, during the end of the onsite week, said it would complete:

1. Consultation/appointment with an epileptologist in Dallas;
2. Reliable documentation of all seizures and falls;
3. Special Grand Rounds and/or IDT/PNMT planning meeting(s) that generates various actions to be taken; and

4. Implementation/results of the actions recommended/taken.

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.

At the time of the last review, this Domain contained 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. Twenty-four of these indicators were moved to, or were already in, the category of less oversight after the last review.

Since the last review, DOJ and the State agreed that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions, and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that will be measured through Section J.12. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Abilene SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor one outcome and two indicators previously in this Domain.

The topics that four indicators in the incident management section previously covered (i.e., Indicators 20 to 23) are now addressed in the quality assurance/improvement tool, so these four indicators have been removed from monitoring. As a result, this Domain now contains 23 outcomes, and 60 underlying indicators. Twenty-two indicators were moved to, or were already in, the category of less oversight after the last review. Presently, four additional indicators will move to the category of less oversight in the areas of restraint, and incident management. This includes the entirety of restraint Outcomes #5 and #6.

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

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

<u>Restraint</u>
Abilene SSLC maintained an already low trend in the frequency of use of crisis intervention restraint; third lowest in the state. The average duration of a crisis intervention physical restraint was the lowest in the state, at less than one minute.

There was good management of restraint usage at the Center. This included thorough analysis of restraint data by the Director of Behavioral Health Services and the Restraint Reduction Committee.

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

Some improvement was noted with regard to nurses' completion of assessments after individuals were restrained. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and conducting assessments to determine whether or not individuals have sustained injuries, and providing follow-up when they do.

Particularly noteworthy was the Center's documentation associated with restraint review. Post-restraint Individual Support Plan Addenda (ISPAs) were completed for nearly all restraints, even when not required because an individual had a crisis intervention plan (CIP). They were comprehensive and almost always included relevant recommendations.

Restraint reduction committee was active; good discussion and review occurred at the meeting observed by the Monitoring Team and shown in the previous months' meeting minutes.

<u>Abuse, Neglect, and Incident Management</u>
There are two priority topics for improvement:

- Unusual Incident Reports (UIRs) often did not include sufficient explanatory information regarding things like apparent lateness in alleged perpetrator reassignment, apparent late reporting, and development of a narrative describing reporting sequence to determine timeliness of reporting. When there are explainable, and likely acceptable circumstances (which were verbally offered in the onsite preliminary scoring review meeting), these need to be articulated in the UIR. Usually, these explanations will need to include a crosswalk between data in the Health and Human Services Commission Provider Investigations (HHSC PI) report and information gathered in the Center's follow-up review of the HHSC PI report. This is especially important in identifying the reporting sequence to establish whether one-hour timelines were met.
- Documentation of good investigation-review practices by upper management was lacking. There was nothing to reflect reviews by a Review Authority or by the Incident Management Review Team (IMRT). The Center acknowledged as much and reported it would be immediately changing its investigation review practices and hoped to achieve an acceptable level of performance at the next review. That being said, some reviews done by the Incident Management Coordinator (IMC) were documented in the UIR and were, for the most part, very thorough.

Other areas for improvement:

- There were two instances where HHSC PI conducted what was labeled an abbreviated investigation. In both cases, multiple substantive interviews were conducted. Thus, it appeared that these investigations may have been appropriate to have been done as a complete investigation, especially after having established all the relevant facts through these

interviews. Then, the "probable version of events" section of the HHSC PI report would have been completed as a summary to establish justification for the finding.

- Half of the incidents had problems around reporting timeliness. On the positive, the Center self-identified this problem in three of the seven cases where this occurred.
- Many investigations did not contain recommendations when it seemed that they should have. In two cases, there was incomplete follow-up on implementation of recommendations.
- Serious injury audits were incomplete.
- There were instances where non-serious injury investigations were not done when needed.

Some positive observations:

- Supports were in place to have reduced the likelihood of incidents occurring for all but one case, resulting in a 92% score for indicator 1.
- Staff knowledge of abuse, neglect, and exploitation (ANE) identification and reporting was acceptable.
- Individual Support Plan (ISP) information about ANE for guardians was acceptable.
- Specific required elements were present in all investigations. The collection and analysis of evidence indicators improved compared with the last two reviews.
- Recommendations flowing from investigations were, for the most part, appropriate, and there was evidence to show their completion.
- There was one investigation chosen for review that was a clinical referral back to the Center. The investigation met most of the procedural criteria that we look for, that is, all except for timely reporting and timely completion.

Other

IDTs were discussing pretreatment sedation (PTS). In two of the three examples, the teams determined that PTS was the best approach. For the third, a toothbrushing plan was put in place, but not monitored for progress.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.	
Summary: Abilene SSLC again demonstrated good management of the use of crisis intervention restraint, as well as restraints for medical/dental purposes. Overall, there was low usage of restraint, and good review of its usage. The director of behavioral health services was knowledgeable about restraint, its usage at the Center, and Settlement Agreement requirements. Additional comments regarding restraint reduction committee and the usage of Ukeru pads at Abilene SSLC are presented below, too. These indicators remain in active monitoring.	Individuals:

#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	92% 11/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	90% 9/10	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 (November 2018 through July 2018) were reviewed. Overall, Abilene SSLC maintained a low rate of application of crisis intervention restraint, remaining the third lowest in the state when comparing census-adjusted rates. There was a slight ascending trend within this nine-month period, due to an increase in one month for one individual (Individual #444). Due to a need for supervision because of frequent falls, he was provided one-to-one supervision. Often, he didn't want staff to be with him all the time and this led to exhibition of behaviors that created a dangerous situation.

The trend in usage of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint because most crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention physical restraint was the lowest in the state, at under one minute. Restraints of less than 30 seconds were calculated as 0 duration, which brought down the average, however, the Center reported that vide of every restraint application was reviewed (unless it occurred in an area with no camera) and most were three to five seconds long.

There were no occurrences of crisis intervention chemical restraint. There were two occurrences of crisis intervention mechanical restraint. These were part of an approved crisis intervention plan and were mittens. There were no individuals for whom protective mechanical restraint for self-injurious behavior (PMR-SIB) was used. The Center reported no injuries occurring during any restraint application. The number of individuals who had one or more crisis intervention restraint per month, however, was showing an ascending trend to about seven different individuals each month.

The Center continued to manage and monitor data on usage of non-chemical and chemical interventions to assist individuals with the completion of medical and/or dental procedures. Usage was low and stable. The Center provided a good narrative analysis of each of these four data sets.

Thus, facility data showed low/zero usage and/or decreases in 11 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; 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.

Restraint reduction committee: Restraint reduction committee was active and completed a restraint report each month. Documentation of the June and July 2019 meetings showed extensive review of Center data and trends. Both included recommendations for improvement. The director of behavioral health services was very knowledgeable about restraint, restraint management, and the requirements of the Settlement Agreement regarding restraints. During the onsite visit, an observation was conducted of the Restraint Reduction Committee meeting. In addition to reviewing crisis restraints, the members of this committee reviewed any chemical or physical restraints used to complete medical or dental procedures, the use of the respite home, and the application of the Ukeru pads. The BHS director reported that she had begun inviting unit directors and new employee orientation staff to allow for their input regarding Ukeru and restraint. These were all positive aspects of this committee.

Ukeru pads: During the restraint reduction committee meeting, there was discussion regarding staff discomfort or unfamiliarity with the Ukeru pads. Suggestions included reviewing potential crisis situations that would warrant the use of these pads during new employee orientation. It was also suggested that refresher training be provided to staff who had received initial training. Staff are also advised to consider the effect of these pads on the individuals served. For instance, while observing the use of a blocking pad with Individual #242, the pad was held up even when he was not displaying potentially dangerous behavior. This could, in fact, suggest a form of intimidation. Because the Center served individuals who can display significantly challenging behavior, staff should be prepared to employ restraint when Ukeru pads are not sufficient and when the situation poses a risk of harm to the individual or others.

2. Three of the individuals selected for review by the Monitoring Team were subject to restraint. The Monitoring Team also reviewed a physical restraint for one other individual. Of these four individuals, all four received crisis intervention physical restraints (Individual #423, Individual #444, Individual #469, Individual #530). 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 six individuals selected by the Monitoring Team had no restraints making a total of nine 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: Abilene SSLC scored 100% for the individual to whom this indicator applied. 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	423	444	469	530					
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.										
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.										

7	There was no injury to the individual as a result of implementation of the restraint.											
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.											
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	100% 1/1	Not rated	Not rated	Not rated	1/1						
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.											
Comments:												

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.												
Summary:			Individuals:									
#	Indicator	Overall Score										
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.												
Summary: These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	423	444	469	530						
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	80% 4/5	2/2	0/1	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: 13. For Individual #444 9/10/18, the restraint monitor arrived, but after 34 minutes.												

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.												
Summary: Some improvement was noted with regard to nurses' completion of assessments after individuals were restrained. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and conducting assessments to determine whether or not individuals have sustained injuries, and providing follow-up when they do. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	423	444	469	530						
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	80% 4/5	1/2	1/1	1/1	1/1						
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	60% 3/5	0/2	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.	33% 1/3	0/2	N/A	1/1	N/A						

Comments: The restraints reviewed included those for: Individual #423 on 5/19/19, and on 6/17/19; Individual #444 on 6/21/19; Individual #469 on 6/13/19; and Individual #530 on 6/24/19.

a. through c. For Individual #423 on 5/19/19, Individual #444 on 6/21/19, Individual #469 on 6/13/19, and Individual #530 on 6/24/19, the nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. This was good to see.

For Individual #423, the following issues were identified:

- For the restraint on 6/17/19, the nurse did not assess mental status.
- For the restraint on 5/19/19, injury was marked as "no" and as "yes." The description indicated: "biting her arm resulting in open wound." However, no documentation was found to show the nurse provided treatment for the injury.
- For the restraint on 6/17/19, nursing staff documented no information related to an assessment for injuries and/or the need for action.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: Given sustained high performance, this indicator (15) will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall	423	444	469	530						

		Score										
15	Restraint was documented in compliance with Appendix A.	100% 5/5	2/2	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: Given sustained high performance, these two indicators (16 and 17) will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	423	444	469	530						
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 5/5	2/2	1/1	1/1	1/1						
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 5/5	2/2	1/1	1/1	1/1						
Comments:												

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)												
Summary:			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: Supports were in place to have reduced the likelihood of incidents occurring for all but one case, resulting in a 92% score for this indicator. Some investigations labeled/conducted as abbreviated by HHSC PI should more appropriately have been conducted as a full investigation. This indicator remains in active monitoring.	Individuals:

#	Indicator	Overall Score	423	298	557	239	444	469	463	78	498
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	92% 11/12 75% 3/4	3/3	1/1	1/1	0/1	1/1	1/1	1/1	1/1	2/2

Comments:
The Monitoring Team reviewed 12 investigations that occurred for nine individuals. Of these 12 investigations, eight were HHSC PI investigations of abuse-neglect allegations (two confirmed, four unconfirmed, one inconclusive, one clinical referral). The other four were for facility investigations of serious injuries (fracture, laceration), and unauthorized departures. 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 #423, UIR 37407, HHSC PI 47610894, confirmed allegation of neglect, 1/22/19
- Individual #423, UIR 39360, HHSC PI 47666758, unconfirmed allegation of physical abuse, 3/9/19
- Individual #423, UIR 43780, HHSC PI 47807602, unconfirmed allegation of neglect, 6/18/19
- Individual #298, UIR 40281, HHSC PI 47693145, unconfirmed allegation of physical and sexual abuse, 3/29/19
- Individual #469, UIR 41528, HHSC PI 47731196, unconfirmed allegation of neglect, 4/26/19
- Individual #463, UIR 39433, HHSC PI 47667679, confirmed allegation of neglect, 3/11/19
- Individual #78, UIR 39473, HHSC PI 47669067, clinical referral of an allegation of neglect, 3/11/19
- Individual #498, UIR 43049, HHSC PI 47784823, inconclusive allegation of neglect, 5/29/19 (UIR 42967 below is the serious injury facility investigation of this injury)
- Individual #498, UIR 42967, discovered fracture, femur, 5/29/19 (this is the facility investigation of the above neglect allegation)
- Individual #557, UIR 41355, unauthorized departure, 4/21/19
- Individual #239, UIR 43683, unauthorized departure, 6/15/19
- Individual #444, UIR 44716, witnessed injury, laceration, forehead, 7/3/19

1. For all 12 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For all investigations, criminal background checks and duty to report forms were completed and available for review. For the eight investigations that were of allegations of abuse, sub-indicators a, b, and c did not apply. For three of the other four investigations, criteria for these three sub-indicators were met, which was good to see. For Individual #239 UIR 43683, there was a PBSP that included

elopement/departures (b), but there was no evidence of implementation of the PBSP and communication strategies (c), or revision of the plan to address the food searching/foraging behaviors that contributed to these elopements.

Note: There were two instances where HHSC PI conducted what was labeled an abbreviated investigation. In both cases, multiple substantive interviews were conducted. Thus, it appeared that these investigations may have been appropriate to have been done as a complete investigation, especially after having established all the relevant facts through these interviews. Then, the "probable version of events" section of the HHSC PI report would have been completed as a summary to establish justification for the finding.

There were no individuals at Abilene SSLC who were designated for streamlined investigations.

Use of respite home: The Center noted that this restriction was reviewed on a case by case basis and only utilized to minimize risk of danger evidenced by observed behavior necessitating the decision to use the respite home. There were two usages for commentary:

One was the use of the respite house for Individual #563 and seemed a reasonable usage. She was recently admitted from living with her family and after a few days, displayed severe self-injury and aggression. She returned to her home each night, awoke without prompting, consumed breakfast with her housemates, and received her morning medications before going to the respite home. While there, she was not forced to remain in the building and was encouraged to participate in activities. A plan was developed to help ensure a gradual successful transition back to her home.

The respite house was last used with individual #298 in March of 2016. He had a current Crisis Intervention Plan, completed in July 2019. If behavioral health services determined that he should be temporarily moved to this home, guidelines indicated that he was to remain there for 24 hours. He could not leave the home unless there were emergency or extenuating circumstances, and he could not associate with others. (He was allowed to make phone calls.). If he tried to leave the home, his exit was to be blocked. Staff are advised to obtain input from senior staff at the state level and appropriate ethical committees if respite home implementation is to be used for him.

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

Summary: Half of the incidents had problems around reporting timeliness. On the positive, the Center self-identified this problem in three of the six cases where this occurred. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 423	298	557	239	444	469	463	78	498
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	50% 6/12	2/3	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/2

Comments:
2. The Monitoring Team rated six 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.

The Center self-identified three of these six as a late report. It was good to see that, at least in some instances, the Center was able to do so.

UIRs often did not include sufficient explanatory information regarding things like apparent lateness in alleged perpetrator reassignment, apparent late reporting, and development of a narrative describing reporting sequence to determine timeliness of reporting. When there are explainable, and likely acceptable circumstances (which were verbally offered in the onsite preliminary scoring review meeting), these need to be articulated in the UIR. Usually, these explanations will need to include a crosswalk between data in the HHSC PI report and information gathered in the Center's follow-up review of the HHSC PI report. This is especially important in identifying the reporting sequence to establish whether one hour timelines were met.

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 #423 UIR 37407: The incident was reported seven days after it occurred. There was conflicting information as to whether the investigator surmised the reporter to be staff or the individual (self-report). Also, the incident occurred in the living room, so there may have been other staff present who might have witnessed and reported the occurrence. There were many omissions in the UIR.
- Individual #469 UIR 41528: The HHSC PI reported showed that the incident occurred at 3:30 pm and was reported at 5:23 pm. The UIR indicated the reported was a staff member and that facility director notification was at 4:50 pm. The UIR did not address this late reporting.
- Individual #463 UIR 39433: The incident occurred at 8:30 am and HHSC PI received the reported allegation at 9:42 am. Facility director notification was at 10:18 am. This was one of the incidents that the UIR acknowledged as late reporting by an unknown reporter.
- Individual #78 UIR 38473: This was reported late and was another one of the incidents that the UIR acknowledged as late reporting by an unknown reporter. There was no exploration of the reporter and late reporting circumstances, such as suspecting that it was a family member.
- Individual #498 UIR 43049: This was the third of the incidents that the UIR self-acknowledged as a late report.
- Individual #557 UIR 41355: The information in the UIR was confusing. That is, the UIR showed that the incident occurred at 10:00 pm and was reported to the Center at 12:04 am, and the individual was located (after unauthorized departure) at 9:43 pm. But on another page, it shows that it was reported to the facility director at 10:12 pm. There was no attempt to reconcile these conflicting times.

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

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary: Specific required elements were present in all investigations for this review and the previous three reviews, too (with one exception at the last review). Therefore, indicator 8 will be moved to the category of requiring less oversight. The collection and analysis of evidence indicators improved compared with the last two reviews. Those indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	423	298	557	239	444	469	463	78	498	
8	Required specific elements for the conduct of a complete and	100%	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	2/2	

	thorough investigation were present. A standardized format was utilized.	12/12									
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 12/12	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	2/2
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	83% 10/12	1/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	2/2
Comments: 10. In two of the investigations for Individual #423 (UIRs 39360 and 43780), the HHSC PI report showed no data under the points of agreement, points of disagreement, credibility, and probable version of events sections. This is usually the case in an abbreviated investigation, but there was no notation in the HHSC PI report that this was designated as an abbreviated investigation. Further, the HHSC PI reports show a number of substantive interviews and video review, so there should have been some commentary addressing the above four sections of the report. State Office, in response to the draft version of this report, indicated that they would talk with the local HHSC PI office about documentation of abbreviated case closure.										

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Two investigations were not completed timely (indicator 12). One was the facility's own clinical referral investigation, the other was Individual #469 UIR 41528 for which the first staff interviews did not occur until day 17. State Office, in response to the draft version of this report, indicated that the local HHSC PI office would be notified of this. This indicator will remain in the category of requiring less oversight. Regarding indicator 13, the Center needs to look at its overall investigation management program. Indeed, the Center acknowledged this during the onsite review and planned to institute improvements in the review of investigations. Indicator 13 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	423	298	557	239	444	469	463	78	498
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/QA specialist (unless a written extension documenting extraordinary circumstances was approved in writing).										
13	There was evidence that the supervisor/QA specialist had conducted a review of the investigation report to determine whether or not (1)	0% 0/12	0/3	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/2

	the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.										

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

Documentation of good investigation-review practices by upper management was lacking. There was nothing to reflect reviews by a Review Authority or by the Incident Management Review Team (IMRT). The Center acknowledged as much and reported it would be immediately changing its investigation review practices and hoped to achieve an acceptable level of performance at the next review. That being said, some reviews done by the Incident Management Coordinator (IMC) were documented in the UIR and were, for the most part, very thorough.

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: The Center did not maintain completion of all aspects of significant serious injury audits for one-third of the individuals. The Center should address and correct this (see comments below). For non-serious injury investigations, some individuals did not need one, but there were non-serious injuries for more than half of the individuals for which a NSI investigation should have been conducted, but wasn't. Indicator 15 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	423	298	557	239	444	469	463	78	498
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.	44% 4/9	0/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1

Comments:
14. For three of the nine individuals, all of the components of a significant serious injury audit were not completed (Individual #469, Individual #463, Individual #498).

15. For five individuals, non-serious injury investigations were not conducted for non-serious injuries for which a non-serious injury should have been conducted based upon the location of the injury (e.g., face, scalp). For some, the investigation did not complete the important question regarding was ANE suspected.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.												
Summary: Many investigations did not contain recommendations when it seemed that they should have (indicator 16). In two cases regarding indicator 17, there was incomplete follow-up on implementation of recommendations. Indicator 17 will remain in the category of requiring less oversight given the Center's past performance. Indicator 16 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	423	298	557	239	444	469	463	78	498
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	60% 3/5	1/2						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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.										

Comments:

16. In nearly all investigations in this review, the UIR did not contain any recommendations.

For the two that did not meet criterion, there were no recommendations when there was confirmed neglect and HHSC PI concerns (Individual #423 UIR 37407, Individual #463 UIR 39433).

17. Two of four investigations to which this indicator applied did not meet criterion with this indicator. For Individual #463 UIR 39433, the UIR noted that two employees would receive re-training, but there was no documentation of occurrence of this re-training. For Individual #498 UIR 43049, nursing stated it would not be taking the recommendation, but there was nothing further provided to show if there was any follow-up or reconciliation of this.

The Monitoring Team also looks to see if employment of any staff was maintained after a confirmed physical abuse 2 occurrence. During the review period, there were no confirmations of physical abuse category 2 at Abilene SSLC.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists one facility indicator. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score										

19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Monitoring of the Center's quality improvement program is now presented in the separate document "Monitoring Team Report for Quality Improvement Review."									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.										
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.										
23	Action plans were appropriately developed, implemented, and tracked to completion.										
Comments: 19. There was tracking and trending of all seven data sets.											

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: For the one individual reviewed who required TIVA/general anesthesia during this monitoring period, the Center did not provide stringent post-operative monitoring as required. In addition, State Office had not issued, and the Center had not implemented preoperative assessment procedures to identify and address risks, including perioperative management. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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	0/1	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments. a. The documentation indicated Center medical staff completed a medical clearance assessment, but it provided no evidence that an appropriate perioperative risk assessment was completed. The Center's policies with regard to criteria for the use of TIVA and general anesthesia as well as the policies related to perioperative assessment and management needed to be expanded and improved to address this concern. Until the Center is implementing improved policies, it cannot make assurances that it is following											

proper procedures. Dental surgery is considered a low-risk procedure; however, the individual may have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation should also address perioperative management, which includes information on perioperative management of the individual's routine medications. A number of well-known organizations provide guidance on completion of perioperative evaluations for non-cardiac surgery.

On 5/17/19, Individual #406 received total intravenous anesthesia (TIVA)/general anesthesia for dental treatment in a hospital setting. Based in review of the documentation provided, the documentation indicated the presence of informed consent and a pre-operative note that defined the procedures completed and an assessment, and confirmation of nothing-by-mouth status. However, upon Individual #406's return to the Center, the documentation indicated gaps in the required monitoring of post-operative vital signs on 5/17/19, and 5/18/19. On 5/19/19, she experienced emesis, and on 5/21/19, she was hospitalized until 6/19/19 for treatment of a gastrointestinal bleed, a urinary tract infection, and sepsis.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	62% 8/13	4/7	N/A	0/1	N/A	1/2	1/1	N/A	N/A	2/2

Comments: For five of the nine individuals reviewed, the Monitoring Team reviewed 13 uses of pre-treatment sedation for medical procedures. These included those for Individual #469 for a barium enema on 2/8/19, a DEXA scan on 5/30/19, ophthalmology appointment and labs on 6/17/19, ophthalmology appointment on 6/24/19, echocardiogram on 7/8/19, cataract surgery on 1/2/19, and esophagogastroduodenoscopy (EGD) on 5/23/19; Individual #100 for cystoscopy on 7/23/19; Individual #383 for cataract surgery on 2/6/19, and mammogram on 7/17/19; Individual #406 for nephrostomy tube replacement on 7/19/19; and Individual #382 for liver ultra sound on 6/27/19, and mammogram on 7/15/19.

The following concerns were noted:

- For Individual #469's pre-treatment sedation for a barium enema on 2/8/19, Center staff did not submit a medical restraint plan. Informed consent also was not obtained/provided.
- For Individual #469's pre-treatment sedation for an echocardiogram on 7/8/19, nurses did not adhere to the schedule for monitoring the individual's vital signs.
- For Individual #469's pre-treatment sedation for the EGD on 5/23/19, nursing staff did not obtain pre-procedure vital signs.
- Upon Individual #100's return to the Center on 7/23/19, nurses did not adhere to the schedule for monitoring the individual's vital signs.
- For Individual #383's pre-treatment sedation for a mammogram on 7/17/19, Center staff did not submit a medical restraint plan. Informed consent also was not obtained/provided.

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 two of the three examples, the teams determined that PTS was the best approach. For the third, a toothbrushing plan was put in place, but not monitored for progress. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 423	298	557	239	563	444	369	469	463
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	100% 3/3		1/1	1/1			1/1			
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	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.	100% 1/1			1/1						
4	Action plans were implemented.	100% 1/1			1/1						
5	If implemented, progress was monitored.	100% 1/1			1/1						
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1			0/1						

Comments:

1-2. Three of the individuals had received pretreatment chemical restraint . A review is provided below for each of these individuals.

- Individual #298 was sedated for "surgical clearance for left leg endogenous laser treatment and bilateral leg stab phlebotomy." The surgery was discussed at an ISPA meeting. Prior to this surgery, his IDT agreed to have the behavioral health assistant accompany him to surgery, reinforce him with a lunch outing for cooperating with surgery, and contacting his grandparents to determine whether they could also accompany him to surgery. There was evidence of informed consent. No action plans were identified to reduce the use of PTS for this invasive surgery.
- Individual #444 was sedated for replacement of his VNS battery. This surgery was discussed at an ISPA meeting. There was evidence of informed consent. No action plans were identified to reduce the use of PTS for this invasive surgery.

- Individual #557 had a Medical Restraint Plan that outlined the use of sedation for medical and dental procedures. This was recognized as a rights restriction in his ISP and there was evidence of an emergency rights restriction. Informed consent had been provided by his LAR and the Human Rights Committee. The only accommodation identified in the MRP was to have familiar staff accompany him to appointments. However, he did have a toothbrushing SAP identified in his ISP.

3-6. There was evidence that a toothbrushing SAP had been implemented to improve Individual #469's oral hygiene. Over a six month period, the number of scheduled trials were implemented between 13% and 96% of the time, for a mean of 64%. Implementation was improving, however, Individual #469 was not making progress and there was no evidence of changes to his SAP.

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	435	521	254	42					
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 improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	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% 0/1	N/A	N/A	0/1	N/A					

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

- On 12/13/18, Individual #435 died at the age of 58 with causes of death listed as acute renal failure with uremia due to inability to accept enteral feedings/fluids, inoperable duodenal stenosis, and severe levo-scoliosis with distortion of body habitus.

- On 12/23/18, Individual #521 died at the age of 54 with causes of death listed as internal hemorrhage and exsanguination, and Stage 4 endometrial adenocarcinoma.
- On 2/9/19, Individual #254 died at the age of 68 with causes of death listed as acute hypoxemic respiratory failure, and aspiration pneumonia.
- On 2/10/19, Individual #42 died at the age of 43 with causes of death listed as uremia, chronic encephalopathy with dysphagia and intolerance of enteral feedings, and brain damage and cerebral palsy.
- On 3/4/19, Individual #167 died at the age of 72 with causes of death listed as uremia, and hepatocellular carcinoma of the liver.
- On 3/21/19, Individual #306 died at the age of 72 with causes of death listed as aspiration pneumonia, anaphylactic reaction to perioperative medication with shock, and hiatal hernia with gastroesophageal reflux disease (GERD).
- On 8/11/19, Individual #52 died at the age of 79 with causes of death listed as pending.

b. through d. Evidence was not submitted to show the Center staff conducted thorough reviews of the care and treatment provided to individuals, or an analysis of the mortality reviews to determine additional steps that should be incorporated into the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. The following provide some examples of problems noted:

- Given that a number of individuals who died had renal stones (e.g., Individual #435, and Individual #42), an interdisciplinary group, including medical, pharmacy, nursing, and residential staff should have conducted a critical analysis of the Center's guidelines, procedures, and practices related to the prevention and treatment of renal stones, and their complications. Such a group should have reviewed and analyzed these individuals' records related to, for example, hydration, medications that contribute to renal stones, pain control, stone analysis, etc. The group should have considered a recommendation(s) related to training on the etiology of renal stones, as well as preventive steps, treatment, etc. In addition, further inquiry for individuals still residing at the Center with this diagnosis, and/or with related commonalities with the individuals who died (e.g., medication usage, etc.) also should occur.
- Individual #42 presumably died of uremia and intolerance of enteral feedings, but there was no review of how long she had these concerns and/or the steps the Medical Department took to prevent and or treat the complications/recurrence.
- For Individual #435:
    - One of the limiting factors was his ineligibility for jejunostomy tube (J-tube) placement, because he was considered to be at high risk due to his body habitus, as well as his behavioral history of pulling out a prior enteral feeding tube. An in-service training for the PCPs reviewing the pre-operative risk factors for abdominal surgery as well as the consultations that are needed to identify and address the pre- and -perioperative risks for individuals with co-morbid high risk factors (e.g., cardiology, pulmonology, nephrology, etc.) would have been an added opportunity for learning.
    - As noted above, one reason the individual was not a candidate for surgery was his history of pulling out his last feeding tube. When an individual pulls out a feeding tube, the IDT needs to review the cause, and track such events, if they recur. The various departments involved in daily care (e.g., nursing, residential) should have a system to document and a system to prevent the causes of such events to the extent possible. The death reviews did not address these topics to identify whether or not the IDT completed the necessary steps.
- For Individual #521 and Individual #435, the submitted documents did not include a Medical Department review, suggesting that critical reviews of these individuals' medical histories and care were not completed, or were not available for the clinical

and/or administrative death review meetings.

- Based on a review of information available for Individual #521, an in-service training for the PCPs concerning the diagnosis, clinical course, and treatment options for an individual with endometrial cancer would have been appropriate.
- In response to Individual #254's death, Center staff missed an opportunity to provide in-service training on the treatment and complications of status epilepticus, which in this case was presumed to be accompanied with silent aspiration.
- Individual #42 was fed enterally, yet continued to lose weight and became cachectic. An in-service training regarding the potential causes (e.g., migration of the feeding tube, malabsorption of nutrients, etc.) would have been a helpful addition to the PCPs' knowledgebase. In addition, it was not clear what other causes of failure to thrive were ruled out (e.g., occult cancer, etc.), so an in-service training related to other causes of decline would have been appropriate.
- Individual #521 was admitted to hospice services only two days prior to her death. This would have been an opportunity to review the eligibility requirements to determine how individuals could, or if they could be referred at an earlier stage in their terminal decline to benefit from hospice services. In addition, it would have been appropriate to review the role of each department (e.g., medical, nursing, behavioral, psychiatry) in contributing to hospice care.
- For Individual #254's death, the Administrative Death Review record indicated that there was a lack of communication in the direct support professional records, but the group did not generate a recommendation to address this concern.

e. For the four individuals reviewed, the mortality review committee generated few recommendations (i.e., a total of two recommendations). However, some improvement was noted with regard to mortality committee writing recommendations in a way that helped to ensure that Center practice improved. For example, a recommendation that read: "RNs assigned to the home will be retrained on reviewing the BM [bowel movement] log weekly and documenting the review in IRIS" resulted in an in-service training, but the Clinical Death Review Committee also appropriately required three months of audits of the BM logs for a random sample of 10% of the individuals in each home to check that RNs had conducted and documented reviews in IRIS. If these audits showed compliance of 90% or greater, then the schedule would reduce to quarterly audits.

The documentation the Center provided made it difficult to determine whether or not, and when a Clinical Death Review recommendation was considered closed. For example, for the recommendation cited above, Center staff submitted in-service sign-in sheets, but it was not clear whether or not all relevant staff were trained. A QA/QI presentation also was submitted, but its relevance was not clear. In addition, the chart that listed the recommendations did not include a column to indicate the date on which the recommendation was initiated and a date on which it was closed, or to provide a "pending" status update.

Quality Assurance

Since the last review, based on the Center's scores over the past three monitoring cycles, DOJ and the State agreed that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions (i.e., see below), and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that will be measured through Section J.12. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Abilene SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the outcomes and indicators related to the exited provisions of the Settlement Agreement.

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	ADRs are reported immediately.	100% 4/4	2/2	N/A	2/2	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% 4/4	2/2		2/2						
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 4/4	2/2		2/2						
d.	Reportable ADRs are sent to MedWatch.	100% 4/4	2/2		2/2						
Comments: a. through d. For two of the nine individuals reviewed, staff identified potential adverse drug reactions, and reported them timely. Providers took necessary clinical follow-up. The Pharmacy and Therapeutics Committee thoroughly discussed them. All four were sent to MedWatch.											

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-nine 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, medical, and dental.

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 the ISPs reviewed, not all needed assessments were identified; this was a decrease since the last review. Those assessments that were identified, however, were completed and submitted in a timely manner.

The psychiatric team continued to complete the annual psychiatric treatment plan updates in a timely manner and with the required content.

A behavioral health assessment was current for about one-third of the individuals. The functional behavior assessment was current and complete for about three-fourths of the individuals.

One-third of the individuals did not have vocational assessments. Two individuals were still in public school, but they were within the transition years of their educational experience and should be preparing for post-graduate work. Some other individuals had no scheduled activities outside of their homes. Their interests and strengths should be carefully assessed to determine potential jobs.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), and use the risk guidelines when determining a risk level. 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.

On a positive note, since the last review, improvement was noted with regard to the timeliness of annual medical assessments (AMAs). Four of the nine AMAs reviewed met criteria for quality. Center staff should continue to improve the quality of the medical assessments with particular focus on the inclusion of thorough plans of care for each active medical problem.

In addition, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. Moreover, for the individuals reviewed, PCPs generally did not complete interval medical reviews (IMRs). Occasionally, individuals had them completed at six-month intervals, which was not adequate, given their high-risk conditions.

The Dental Department provided the newly admitted individual reviewed with a timely dental exam and a timely dental summary. The Dental Department also generally provided individuals reviewed with good quality annual dental summaries. As a result of sustained progress in these areas, two related indicators will transition to the category of less oversight. For most of the individuals reviewed, comprehensive dental examinations included all of the required components, and the remaining exams reviewed included most of the required components. With sustained efforts in this area, after the next review, the related indicator might also move to the category requiring less oversight.

For the nine individuals reviewed, nurses completed timely annual or new-admission nursing reviews and physical assessments. They also completed timely quarterly nursing record reviews and/or physical assessments for the eight individuals needing them.

With regard to the quality of nursing assessments, it was positive that for 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.

The Physical and Nutritional Management Team (PNMT) did not conduct reviews or assessments for a number of individuals reviewed that met criteria for PNMT involvement. Of significant concern, the PNMT appeared to defer formal reviews to the IDTs with the explanation that the IDT had not yet had time to and/or developed plans to address the PNM issue. It is essential to understand that at the point that an individual meets criterion for PNMT involvement, a threshold has been crossed that requires external review of the IDT's work (i.e., a second opinion). As such, the PNMT needs to conduct at least a formal review, and when necessary a formal assessment to the depth and complexity necessary to meet the individual's needs.

The PNMT also often concluded that the "root cause" of the PNM issue had been previously identified, when sufficient investigation of true "root causes" had not occurred. This showed a lack of understanding of "root cause analysis." In other words, true analysis of the underlying etiology would require further inquiry into "why": for example, why the small bowel obstruction that might have been a cause of aspiration pneumonia occurred, including inquiring about factors such as positioning, activity level, fluid intake levels, fiber intake, etc., etc.

For this review, timeliness of Occupational Therapy (OT)/Physical Therapy (PT) assessments for the annual ISP did not appear to be a significant concern, but OTs/PTs frequently did not complete other needed assessments. While it was positive to see some improvement, the quality of OT/PT assessments continues to be an area on which Center staff should focus.

Overall, timeliness of communication assessments had improved. However, significant work is needed to improve the quality of communication assessments and updates in order to ensure that speech language pathologists (SLPs) provide IDTs with clear understandings of individuals' functional communication status; augmentative and alternative communication (AAC) options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated.

Individualized Support Plans

Eighteen personal goals were rated as being individualized and meaningful. This was good progress and showed that Abilene SSLC had the capacity to develop these types of personal goals. About half of these were written in measurable terminology.

Most of the goals (and their underlying action plans) were not implemented.

Two of 13 goals had action plans that supported the achievement of those goals.

Training opportunities that would lead towards greater independence and a more meaningful day were still extremely limited. The Center needs to focus on new training opportunities in the day programs. Individuals did not spend a majority of their day out of the home and in day programming that promoted skill building.

Regarding most integrated setting planning, improvement was primarily needed in the depth of the discussion of living options, including a discussion of barriers to referral. ISPs did continue to include a statement of the overall decision of the entire IDT.

Relevant team members were missing from each individual's ISP meeting. ISPs were not implemented within the time requirement.

The QIDP Department experienced a high rate of turnover during the past nine months, including a change in department lead. This possibly contributed to the lack of progress since the last review. Hopefully, the changes in the QIDP Department will lead towards progress.

QIDPs completed monthly reviews and IDTs met frequently to follow-up on incidents (e.g., restraints, peer-to-peer aggression, illness requiring hospitalization). When recommendations were made or supports revised, the IDT did not meet timely to review implementation of those recommendations and supports, or assess the effectiveness of supports.

The psychiatry department continued to make good progress regarding the identification of psychiatric indicators, the creation of psychiatric goals, and inclusion of the goals in the ISP documentation.

Psychiatrists attended ISP meetings for most individuals. The documentation in the ISP met criteria for about two-thirds of the individuals.

In behavioral health services, although the department had lost several Board Certified Behavior Analyst (BCBA) staff, positions had been filled.

There continued to be good progress regarding the collection and assurance of reliable PBSP data. This was very good to see. The Center's system for checking on, and improving, data reliability included regular checks on accuracy and timeliness of data recording. The Monitoring Team, however, observed several instances of target behavior occurrences that were never entered into the data system.

Two PBSPs were complete in content. They included clear guidelines for providing reinforcement for appropriate behavior and the absence of problem behavior.

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: Eighteen personal goal areas had goals that were rated as being individualized and meaningful. This was good progress and showed that Abilene SSLC had the capacity to develop these types of personal goals. About half of these were written in measurable terminology. Most of the goals (and their underlying action plans) were not implemented. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	563	469	463	444	150	411			
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	5/6	2/6	2/6	4/6	3/6	2/6			

2	The personal goals are measurable.	0% 0/6	4/6 4/5	3/6 1/2	1/6 0/2	1/6 1/4	1/6 1/3	1/6 0/2			
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 #563, Individual #469, Individual #463, Individual #444, Individual #150, and Individual #411. The Monitoring Team reviewed in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings at Abilene SSLC.

1. The ISP relies on the development of 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.

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

Below is detail regarding the different categories of personal goals:

- Leisure goals for five individuals met criteria. These were:
  - Individual #563's goal to ride her bike independently around campus.
  - Individual #469's goal to sing in a choir.
  - Individual #444's goal to walk/run in a fun run.
  - Individual #150's goal to independently shop for clothes.
  - Individual #411's goal to schedule an outing to a local coffee shop.
- Leisure goals that did not meet criteria were:
  - Individual #463's goal to independently use her iPod daily was not based on her assessed interests. The goal was put on hold because the IDT was not able to adapt an iPod for her use.

- Four relationship goals met criteria:
  - Individual #563's goal to independently video call with her mother weekly.
  - Individual #469's goal to send arts and crafts projects to his foster friend.
  - Individual #463's goal to increase time visiting with her family.
  - Individual #411's goal to schedule an outing to a local coffee shop.
  - Individual #444's goal to walk/run in a fun run.
- This relationship goal did not meet criteria:
  - Individual #150's goal to mail cards to her family monthly was not aspirational.

- Work/School/Day goal for one individual met criteria.
    - Individual #563's goal to graduate from high school.
- These work/school/day goals did not meet criterion:
    - Individual #469's day goal to send arts and crafts projects to his foster friend on a quarterly basis was not aspirational or likely to result in a more meaningful day.
    - Individual #463's goal to sing in a choir weekly was unlikely to lead to participation in a meaningful day program.
    - Individual #444's goal to earn $13 a month was not individualized, based on an adequate vocational interest, and did not identify functional skills that might lead towards meaningful employment.
    - Individual #411's goal to earn $50 per pay period was not individualized or based on gaining new skills.

- Three of six individuals had a greater independence goal that met criteria. These were:
    - Individual #563's goal to independently complete her bedtime routine.
    - Individual #444's goal to independently purchase a meal in the community.
    - Individual #150's goal to set her place at the table.
- These greater independence goals did not meet criterion.
    - It was not clear how Individual #469's goal to enter an art project in the fair annually would lead towards greater independence.
    - It was not clear how Individual #463's goal to sing in the choir would lead to gaining skills that would lead to greater independence.
    - Individual #411 did not have a greater independence goal.

- Living options goals for Individual #563, Individual #444, and Individual #150 were aspirational goals to move into the community.
    - Individual #463 had a goal to increase her skills of daily living.
    - Individual #469 and Individual #411 had goals to live at Abilene SSLC. These goals were not aspirational since they were already living at Abilene SSLC.

While it was good to see that more goals were individualized and aspirational that at the last review, IDTs need to continue to offer greater opportunities for individuals to explore new interests and activities. For the most part, goals were limited to activities that were readily available at the facility. There was little focus on activities that would provide individuals opportunities to interact in a less restrictive environment.

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

Of the 18 personal goals that met criterion for indicator 1, seven met criterion for measurability. The following goals were not measurable as written, so that all staff could determine when the goal had been accomplished:

- Individual #563's goal to independently complete her bedtime routine daily.
- Individual #469's goal to sing in a choir.
- Individual #463's goals to increase time visiting with her family and increase her daily living skills .
- Individual #444's goal to walk/run in a fun run and his goal to independently purchase a meal in the community.
- Individual #150's goals to independently shop for clothing and her goal to independently set up her own place at the table during meals.
- Individual #411's goal to schedule an outing to a local coffee shop.

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

- Individual #469's work goal to send an art project to his foster friend quarterly and his greater independence goal to enter an art project in the West Texas Fair annually.
- Individual #444's work goal to earn $15 per month working at the work center.
- Individual #411's goal to earn $50 per pay period for one year.

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

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

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

- For Individual #563's goal to complete her bedtime routine, an action plan to develop a picture calendar was a prerequisite to implementing other action plans. The QIDP monthly review indicated that the picture calendar had not yet been created.
- Individual #469 had a goal to sing in the choir monthly. His QIDP monthly reviews indicated that this goal had never been implemented because the facility did not have a choir director. He had a related action plan to develop a SAP for operating his MP3 player, but QIDP monthly reviews from March 2019 through July 2019 indicated that the SAP had never been developed. Another action plan to purchase music had also not been implemented. Action plans to support his relationship and day goal had also not been implemented. His QIDP monthly review indicated "this did not happen" for each related action plan.
- Individual #411's QIDP monthly reviews from March 2019 through July 2019 indicated "did not happen this review period" for each of the action plans related to his recreation/leisure goal to go to a coffee shop with a friend.

As noted throughout this report, for all of the other goals, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of reliable data and documentation provided by the Center. While there were some data collected showing implementation of some action plans, there was not enough information documented to clearly determine the status of goals.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: Overall performance remained low. There were some indicators for which one or two ISPs met criteria. Overall, these ISP action plan characteristics should be assessed and improved. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	563	469	463	444	150	411			
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	0/6	0/6	1/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	33% 2/6	1/1	1/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	17% 1/6	1/1	0/1	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.	33% 2/6	1/1	0/1	0/1	0/1	0/1	1/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	33% 2/6	1/1	0/1	0/1	0/1	0/1	1/1			
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	0/6	0/6			
Comments: 8. Eighteen of the personal goals met criterion in the ISPs, as described above in indicator 1, therefore, those action plans could be											

evaluated in this context (i.e., for this indicator 8). A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

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

- Individual #563's greater relationship goal.
- Individual #444's recreation/leisure goal.

Most of the action plans were written as service objectives and did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress. Many action plans stated what staff would do, but not what action the individual would take to show progress towards accomplishing his or her goal, thus, data would indicate how many times staff had implemented the plan instead of measuring specific progress towards the goal. IDTs still needed to focus on laying out a clear path of assertive action plans to meet each goal.

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

- Individual #563 had a goal to independently ride her bike. Action plans noted that a SAP would be developed after the OT assessed her bike riding skills. The assessment had not been completed and a SAP was never developed. Regarding her goal to graduate from high school, there were two related action plans to enroll in High School and to go shopping for school clothes and school supplies. Her IEP goals should have been integrated into her ISP. Action plans did not include when she would have the opportunity to ride a bike or who would ensure that it happened.
- Individual #469 had a goal to sing in the choir monthly. He had two related action plans to support this goal. One was to attend choir as scheduled and the other was to participate in one choir event such as the Christmas Play, Annual Choir Competition, etc. Action plans did not include supports that were needed or offer guidance for staff to ensure that this was implemented consistently. An additional music related action plan stated that he would purchase music at Second Edition at least once this reporting year. Again, there were no staff instructions to guide staff in carrying out this action plan.
- Individual #411 had a goal to go on an outing at a local coffee shop quarterly with a friend. The IDT did not develop action plans that included supports that he would need in the community or skills that he might gain through this activity.

9. None of the ISPs had action plans that integrated preferences and opportunities for choice. For the most part, goals and action plans were based on individual preferences, however, opportunities for making choices were limited. Action plans ensuring opportunities for work and day programming based on preferences and supported by exposure to new activities were particularly limited. The IDT had ensured that Individual #411's day was based on his individualized preferences and choices including having lunch at the diner daily, eating dinner alone in his room, and continuing to work at 80-years-old. This was positive to see. His ISP action plan, however, did not integrate opportunities to make choices.

IDTs were generally not identifying preferences in a way that might guide the development of activities that would offer opportunities to learn new skills and build on developing a plan for meaningful days. For the most part, ISPs listed general preferences related to food, music, tv, and activities routinely offered at the facility. For example, two individuals had goals to sing in the Abilene SSLC choir based on their interest in music. The IDT did not consider alternate opportunities in the community to sing with a group, gain exposure to new experiences, and build new relationships. The facility did not have a choir director, so related goals were never implemented.

Opportunities to make meaningful choices were limited. Expanding choices may result in discovering new preferences.

10. One of the ISPs clearly addressed strengths, needs, and barriers related to informed decision-making.

A basis to making informed decisions is offering individuals exposure to a variety of new experiences and opportunities to make choices throughout their day. These opportunities were not generally included in action plans for individuals in any substantial way. The exception was for Individual #463. She had an action plan to attend self-advocacy meetings. This was positive to see.

11. One of the ISPs met criterion for this indicator to support the individual's overall independence.
- Individual #563's ISP minimally met this criterion. She had a greater independence goal to complete her bedtime routine independently. This included a SAP to rinse her hair.
- Individual #469's action plans included learning to clean his glasses, toothbrushing, and mailing a letter to his friend.
- Individual #463's greater independence goal to sing in a choir did not include action plans to support gaining skills that would lead towards greater independence.
- Individual #444's goal to purchase a meal in the community could have led to skills that would increase his independence, however, action plans were not developed to support functional skill building.
- Individual #150 had goals for shopping, mailing letters, and setting the table, however, action plans were not developed for functional skill building that would increase her independence.
- Action plans to support Individual #411's independence included cleaning his gums and independently applying his wheel chair brakes. Cleaning his gums appeared to be a compliance issue and he was never assessed for applying his brakes on his wheelchair. During observations, he repeatedly applied his brakes independently and safely without prompts.

12. None of the ISPs integrated strategies to minimize risks in ISP action plans in a meaningful way. While risks were addressed through action plans included in the IHCP, supports were not routinely integrated into other action plans when relevant, and risks were not always identified by the IDT. Rarely were SAPs written to provide staff with strategies for implementing plans and, when SAPs were written, they did not include specific mobility, behavioral, and safe eating supports. In many cases, it was not apparent that there was a sense of urgency when individuals were at high risk for injuries and illnesses. Supports were often fragmented without considering how the IDT could work together to develop comprehensive supports that might address risks. Indicator 13 includes examples of supports that ancillary disciplines had recommended to address risk areas that were not integrated into the ISP.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. While IDTs were attempting to integrate behavioral objectives into action plans to support goals, for the most part, they became stand-alone action plans and were not truly integrated into action plans for functional skill building. For example,
- Individual #563's ISP did not integrate recommendations to address her behavior.
- Individual #469's ISP did not integrate strategies for mobility and communication into any of his action plans. He had experienced a recent decline in health that impacted his programming. The IDT did not consider developing alternative

programming for the days that he did not feel like going to the day program.

- Individual #463's IDT recommended an assessment to explore using an adaptive switch to give her more control over her day. The assessment was never completed and recommendations were not included in action plans.
- Individual #444 had many complex support needs and risks. The IDT needs to take an integrated approach to addressing factors that are placing him at risk. Although the team had developed and revised his supports numerous times, there was little integration of supports into his action plans. Supports were fragmented by discipline with little evidence of coordination between team members to address his risks.
- Individual #150's communication, mobility and behavioral supports were not integrated into action plans to support her goals. For example, the IDT did not integrate any of these supports into action plans related to shopping in the community. IDT members should have clear instructions for providing needed supports across all settings to minimize her risks and ensure that she is successful in reaching her goals.
- Individual #411's QIDP stated that his vision was deteriorating. It was not clear that staff were aware of regression or were addressing it. He was receiving direct therapy for transfers, stability, and ambulation. Those supports were not integrated throughout his ISP.

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

14. One of the ISPs included action plans to support meaningful integration into the community.
    - Individual #563 had action plans related to her going to school in the community.

Although some individuals had goals to live in the community, action plans minimally supported community integration. Individuals did not have goals for banking, volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movies, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

Individual #444's goal to participate in a fun run and Individual #411's goal to visit coffee shops in the community might lead to meaningful integration with others that share their interest, however, the IDT did not develop action plans to support true integration.

15. Two of the ISPs documented the IDT's consideration of opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Comments for all six individuals are below:
    - Individual #563 attended public school.
    - Although Individual #411 was 80-years-old, he clearly enjoyed working and wanted to continue to do so. His IDT continued to provide supports so that he could continue working. They also considered his preferences for how he likes to spend the rest of his day and made sure that supports were available to him.
    - Individual #463 attended the seniors program at the facility. Staff reported that she enjoyed playing games with her peers and liked activities involving music and crafts. Both days that she was in the day program, she refused to participate in activities offered to her. She was asleep in her chair waiting to have her hair done during one observation. Her IDT should assess her for

other areas of interest and focus on skill building activities.

- Individual #444's staff reported that many of his recent injuries were due to trying to get away from staff and activities. He did not have meaningful day programming and there were very few expectations that he would gain new skills that might lead towards employment. He did not have a current vocational assessment that adequately explored his preferences.
- Individual #150 also had few opportunities to learn new skills and explore new interests. She also was not engaged in any type of activity during a majority of observations.
- Individual #469 was scheduled to attend day programming around 30 hours per week. Staff noted that his attendance had been decreasing due to health concerns. His sister told the IDT that he was interested in going back to work. His ISP noted that the IDT would explore this following his eye exam. There was no evidence that the IDT discussed his possible interest in work. Most of his action plans were on hold and the IDT did not develop training that could be implemented on the home when he did not feel like going to the day program.

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

16. Two ISPs supported substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs had limited opportunities for learning and functional skill development. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests, then build on skills related to those preferences. There was a significant lack to vocational training offered by the facility and few individuals had opportunities to work in interesting jobs that paid fair wages.

- See comments in indicator #15 regarding Individual #563 and Individual #411.
- Day programming for other individuals was not based on assessments that identified skills needed to more independently participate in meaningful activities during the day. Action plans generally stated what activity the individual would be engaged in during the day, but did not identify specific training and supports that would be needed to teach new skills.
- Observations of individuals at their day program did not support that individuals had opportunities for functional skill development.

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

18. None of the goals had a set of action plans with enough detail to ensure consistent implementation, data collection, and review. Overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated, not individualized, and, in most cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented. When skill acquisition plans were developed, they also were not adequate for providing staff with guidance to implement plans.

Although IDTs had created some goals that were more individualized and based on known preferences, few had specific teaching strategies to ensure staff were implementing them and measuring success consistently. Additionally, few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The Center needs to focus on barriers that are preventing individuals from achieving their goals and develop action plans to address those barriers.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: See comment below regarding performance on indicator 19, which will, however, remain in the category of requiring less oversight. Improvement is primarily needed in the depth of the discussion of living options, including a discussion of barriers to referral. ISPs did continue to include a statement of the overall decision of the entire IDT. Therefore, indicator 22 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	563	469	463	444	150	411			
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).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1			0/1						
21	The ISP included the opinions and recommendation of the IDT's staff members.	50% 3/6	1/1	1/1	0/1	0/1	0/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	83% 5/6	1/1	1/1	0/1	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.	0% 0/1			0/1						
26	IDTs created individualized, measurable action plans to address any	0%	0/1	0/1	0/1	0/1	0/1	0/1			

	identified obstacles to referral or, if the individual was currently referred, to transition.	0/6									
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1			0/1						
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A									

Comments:

19. Three ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT. For Individual #469, Individual #463, and Individual #411 the ISP did not document discussion by staff of their known living option preferences (i.e., environmental preferences). Their exposure to alternate living options was limited.

20. Individual #463's ISP was observed. The IDT did not discuss a range of options available in the community that might support Individual #463's preferences regarding living options. When asked if Individual #463 liked her house, she replied "no." The IDT did not explore this further.

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

- Individual #463's PCP did not offer an opinion on living options. Other IDT members cited medical needs as barriers to living in the community, however, those barriers were not clearly defined.
- Individual #444's ISP did include the opinion of his PCP or psychiatrist.
- Individual #150's team noted that interventions were very labor intensive and unlikely to be duplicated in the community. It was not clear which supports were not available in the community.

22. All of the ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.

23. None of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. ISPs did not indicate that the IDT had considered other living options that specifically supported their individualized preferences and support needs.

24. Five ISPs identified a list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #463's ISP did not clearly identify which supports were not available in the community.

25. Individual #463's ISP was observed. The QIDP reported that all assessments recommended community referral. She then asked the team present to state their opinion. Individual team members stated vague barriers to referral and agreed not to make a referral. The IDT did not identify specific supports that could not be provided in the community.

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

27. Individual #463's IDT did not develop action plans to specifically address identified obstacles to referral at her annual IDT meeting. Obstacles were not clearly defined.

28. Individuals did not have individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs. ISPs included action plans for the individual to attend a provider fair and group home tours, however, these were not individualized based on the individual or LAR's current knowledge regarding living options or specific to living options that could provide identified supports needed in the community.

29. Barriers were identified to referral for all individuals.

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

Summary: 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.

#	Indicator	Overall Score	Individuals: 563	469	463	444	150	411			
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).	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

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

- For Individual #563, the IDT recommended a bike assessment within 30 days in order to develop a bike riding SAP. Her QIDP monthly review dated 8/8/19 indicated that the assessment was never completed. Her SLP was supposed to develop a picture calendar board for her bedtime routine. Her QIDP monthly review indicated that the IDT was waiting for completion and staff

training.

- As of August 2019, Individual #469 had not had the opportunity to sing in the facility choir. His ISP indicated that he would be assessed for the use of headphones within 30 days. His ISP was developed on 2/13/19. The assessment was not completed until 5/15/19 according to his QIDP monthly review.
- Action plans to support Individual #463's goal to use her iPod were never implemented and she had not had the opportunity to sing with the facility choir during the entire ISP year.
- Individual #444's money management SAP was never developed.
- Individual #150's ISP was developed 4//10/19. Her eating skills SAP was not developed and implemented until August 2019.
- Action plans to support Individual #411's recreation/leisure and relationship goals were never implemented.

33. Two of six individuals attended their ISP meetings (Individual #463, Individual #469).

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.

- The LAR did not attend the annual ISP meeting for Individual #563, Individual #469, Individual #463, and Individual #411.
- Individual #469's PCP did not attend his annual ISP meeting. He had complex medical issues that were impacting implementation of his ISP.
- Individual #444's PCP did not attend his ISP meeting. He remained at a high level of risk for injuries due to unresolved medical issues.
- Individual #150's SLP did not participate in her annual ISP meeting. Her IDT needs guidance on integrating communication supports throughout all activities.

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

Summary: Not all needed assessment were identified; this was a decrease since the last review. Those assessments that were identified, however, were completed and submitted in a timely manner. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	563	469	463	444	150	411			
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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	50% 3/6	1/1	0/1	1/1	1/1	0/1	0/1			

Comments:

35. None of the IDTs considered what the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting.

- Individual #563 would be graduating from high school soon. The IDT had not considered completing a vocational assessment

to identify her work preferences and begin focusing on skills needed to be successfully employed when she graduates.

- Individual #469 expressed an interest in going back to work. His IDT should consider completing a work assessment to determine his preferences and supports needed.
- Individual #463's ISP indicated that the IDT recommended a headphone assessment and switch assessment at the time of her ISP. The IDT should have considered the need for these assessments prior to her ISP meeting so that training could have begun immediately.
- Individual #444's IDT needs to consider a comprehensive vocational assessment to identify his work preferences and training needs. His work goal appears to be compliance related to get him to go to work at a job that he had indicated little interest in doing.
- Individual #411 needs to have a vision exam that clearly identifies his visual acuity. Staff noted concerns regarding his declining vision. If his vision is worsening, the IDT should consider an orientation and mobility assessment to address his risk for falls.

36. Three of the IDTs arranged for and obtained all needed, relevant assessments prior to the IDT meeting.
    - Individual #563's IDT recommended an AAC assessment. It appears that this was never completed.
    - Individual #463's and Individual #444's behavioral health assessments were not completed 10 days prior to their ISP meeting.

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

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

Summary: IDTs met regularly, but didn't take the opportunity to look deeply at action plans and personal goals regarding implementation (lack of) and progress (inability to determine) and then making changes to make improvements. These indicators were not scored for Individual #563 because she was a relatively new admission and her ISP was in place for only about one month at the time of this review. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	563	469	463	444	150	411			
37	The IDT reviewed and revised the ISP as needed.	0% 0/5		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% 0/5		0/1	0/1	0/1	0/1	0/1			

Comments:

37. The IDTs routinely met to review supports, services, and serious incidents during ISPA meetings. IDTs did not routinely revise

supports or goals or address barriers when progress was not evident. As noted throughout this report, data were not available to support consistent implementation. Without adequate data, IDTs were unable to make decisions regarding progress or lack of progress towards goals.

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

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

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

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

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

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

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

#	Indicator	Overall Score	Individuals: 469	563	100	150	383	406	411	425	382
a.	The individual's risk rating is accurate.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	83% 15/18	0/2	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #469 – choking, and falls; Individual #563 – cardiac disease, and weight; Individual #100 – dental, and seizures; Individual #150 – weight, and skin integrity; Individual #383 – respiratory compromise, and seizures; Individual #406 – respiratory compromise, and seizures;

Individual #411 – gastrointestinal (GI) problems, and cardiac disease; Individual #425 – diabetes, and infections; and Individual #382 – choking, and GI problems].

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

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs for individuals within 30 days of admission and updated the IRRFs at least annually. However, when changes of status occurred that necessitated at least review of the risk ratings, IDTs 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 #563 – cardiac disease, and weight; Individual #100 – dental, and seizures; Individual #150 – weight, and skin integrity; Individual #383 – respiratory compromise, and seizures; Individual #406 – respiratory compromise, and seizures; Individual #411 – cardiac disease; Individual #425 – diabetes, and infections; and Individual #382 – choking, and GI problems.

Psychiatry

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

Summary: The psychiatry department continued to make good progress on this set of indicators as reflected in the many 1/2 scores as well as the higher scores for indicators 4, 5, and 6. It is likely that by the time of the next review, criteria will be met for all of the indicators in this outcome. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 423	298	557	239	563	444	369	469	463
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	38% 3/8	0/2	2/2	2/2	2/2		1/2	0/2	0/2	1/2
5	The individual has goals related to psychiatric status.	13% 1/8	0/2	1/2	2/2	1/2		1/2	1/2	0/2	1/2
6	Psychiatry goals are documented correctly.	63% 5/8	2/2	2/2	1/2	0/2		2/2	2/2	1/2	2/2
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

Comments:
The scoring in the above boxes has a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase. Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

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

clinical services, and to increase the likelihood of improvement in an individual's psychiatric condition and behavioral functioning.

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors. In psychiatry, the focus is upon what have come to be called psychiatric indicators.

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

The Monitoring Team looks for:

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

4a. There was at least one indicator to decrease for eight of the individuals in the review group (all but Individual #563 who had only recently been admitted and, thus, goals had not yet been developed). There were indicators for behaviors to increase for seven of the individuals (all but Individual #423, and again for Individual #563).

4b. There was an explanation describing the relevance of the indicators for reduction to the individual's diagnosis for all of these individuals. Psychiatric indicator to increase could be linked to the diagnosis for five of the individuals (all except Individual #444 and Individual #469, as well as Individual #423 and Individual #563 who did not have goals for increase).

4c. The indicators for reduction were defined in observable terms for five of these individuals. That is, not for Individual #423, Individual #369, and Individual #469, for whom the deficits in the documentation were a lack of specificity with regard to the duration and intensity of aggression and or self-injury. The psychiatric indicators for increase were described in observable terminology for five of the individuals. That is, not for Individual #423, Individual #369, and Individual #463.

Thus, all three indicators were met for indicators for reduction for five individuals, and for three individuals for indicators for increase. Overall, all three monitoring indicators were met for both psychiatric indicators for three individuals.

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. A goal for the indicator to decrease was written for all of the individuals. Goals were also written for the psychiatric indicators to increase for all of the individuals.

5e. For goals for decrease, the definition of the psychiatric indicator so that data could be collected, and a description of how they would be collected was present and met criteria for five individuals (not for Individual #423, Individual #369, and Individual #469). For goals for increase, the type of data and how to collect that data were written in an understandable manner for two of the individuals, Individual #557 and Individual #469. The goals for the others did not operationally define what constituted attendance or participation in work settings.

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.

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 indicators to decrease and for increase did appear in the IHCP section of the ISP for seven of individuals (that is, all except Individual #239 because his ISP occurred before the psychiatric team developed the ability to place the goals in the IHCP). The goals appeared in the LTC Behavioral Health section. The goals were identified as psychiatric goals because they either (a) had the prefix PSYCH before the goal, and/or (b) for those that did not have the prefix, the Monitoring Team was able to see the same goal in the psychiatric documentation.

State Office is likely to put forward a standardized way for psychiatric goals to appear in the IHCP (cf. Tier 2 documents .03). One possibility is that there will be a separate LTC Psychiatry section. The Monitoring Team accepted Abilene SSLC's methodology for doing so for this review. For the next review, the Monitoring Team will be looking for the Center to have followed whatever methodology State Office puts forward.

6g. During the course of the year there were changes to the goals for indicators to reduce for two individuals: Individual #557 and Individual #369. It was good to see that the psychiatrists were updating goals and documenting those changes. To meet criteria, there needs to be commentary in the psychiatry note and there also needs to be an ISPA to show that the change was incorporated into the ISP. For Individual #369, the necessary documentation to justify the change was not present. There was commentary explaining the change in the psychiatric quarterlies for Individual #557, but there had not been an ISPA that would involve the broader psychiatric team.

The goals for the psychiatric indicators to increase were not modified over the course of the year for any of the individuals. Thus, no commentary was required.

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. 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.

7. During the course of the onsite review it became apparent that there were deficiencies in the data collection that made the information unreliable and, thus, no valid decisions could be based on that data. For psychiatric indicators that are identical to PBSP target/replacement behaviors, there is often a methodology utilized by behavioral health services to assess and ensure reliability. For psychiatric indicators that are not part of the PBSP, the psychiatry department needs to ensure reliability.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Improvement to 78% was seen regarding consistency of diagnostic information in the record. The one recent admission had a CPE completed, though just beyond the 30-day requirement. Her CPE, moreover, was missing some elements (indicators 13 and 14). Indicators 15 and 16 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 423	298	557	239	563	444	369	469	463
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.	0% 0/1					0/1				
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.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
13-14. For the recent admission, Individual #563, the CPE was missing multiple sections. This should be corrected for her CPE and for all other CPEs, especially new CPEs.

15. Individual #563 was admitted on 5/21/19. Her record contained a CPE completed on 6/22/19, just beyond the 30 day requirement. The admission IPN was done on the day of admission.

16. The psychiatric diagnoses were consistent in the medical, behavioral health and psychiatric sections of the record for seven of the

individuals; all except Individual #423 and Individual #557. The discrepancies were in the medical section of the record as there was congruence for the psychiatric diagnosis in the psychiatric and behavioral sections for all of the individuals.

Outcome 5 – Individuals' status and treatment are reviewed annually.												
Summary: Psychiatrists attended ISP meetings for all but one individual for this review and for the past two reviews, too. Given this sustained high performance, indicator 20 will be moved to the category of requiring less oversight. The documentation in the ISP maintained at meeting criteria for about two-thirds of the individuals. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463
17	Status and treatment document were updated within past 12 months.	Due to the Center's sustained performance, these indicators were 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).										
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.										
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	89% 8/9	1/1	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.	67% 6/9	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1
Comments: 20. A licensed member of the psychiatric team attended the ISP for all of the individuals, except Individual #239. 21. The IRRF component of the ISP met the content requirements for six of the individuals (including the reference to the participation of the member of the psychiatric team).												

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: Indicators 30 and 31 were not met for the recent admission, Individual #563. This should be corrected. These indicators will remain in the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score										
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.											
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.											
32	HRC review was obtained prior to implementation and annually.											
Comments:												

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.												
Summary: Regarding the four indicators that are in the category of requiring less oversight, one individual did not but should have had a PBSP (indicator 1). There continued to be good progress regarding the collection and assurance of reliable PBSP data. This was very good to see. The Center's system for checking on, and improving, data reliability included regular checks on accuracy and timeliness of data recording. The BHS department should now work to get indicator 5 into meeting criteria. It will remain in active monitoring. Note, however, that the Monitoring Team observed several instances of target behavior occurrences that were never entered into the data system. This is another area of focus for the Center relevant to indicator 5.			Individuals:									
#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.										
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. One individual in the review group, Individual #382 should have had a PBSP. She was observed screaming and biting her hand. Further, her most recent behavioral health assessment noted that she engaged in self-injurious and yelling behaviors, and would place items in her mouth. Her IDT discontinued a PBSP after determining that these behaviors served as a means of communication for Individual #382. Because problem behaviors frequently serve communicative functions, staff are advised to complete a functional behavior assessment prior to developing a PBSP. Staff are also advised to review Individual #383's PBSP because pica was no longer a targeted problem behavior although it was noted that she may display this behavior when she is not engaged and staff were advised to keep small items out of her reach.

2. Almost all individuals had objectives related to psychological/behavioral health. The exception was Individual #423 who had objectives for all targeted problem behaviors with the exception of disruptive behavior. Individual #369 had an objective for his replacement behavior, but his PBSP did not identify any targeted problem behaviors.

5. Facility staff are commended for completing routine monitoring of inter-observer agreement on all targeted problem and replacement behaviors. Such monitoring was identified in the individual's PBSP and was scheduled to occur at bi-weekly, monthly, or quarterly intervals of time. Additionally, staff continued to focus on the recording of data every two hours to ensure data timeliness. Thus, performance on this indicator was improving, but had not yet been met for all nine individuals.

During the onsite visit, PBSP data were requested following observations of problem behavior. Findings are summarized below.

- On Monday at approximately 3:40 pm, Individual #411 was observed repeatedly slapping his face. This behavior was not documented. Staff are advised to conduct repeated observations of Individual #411 to determine whether the operational definition of self-injury adequately identifies this behavior.
- On Tuesday at approximately 9:25 am, Individual #444 was observed leaving his home without shoes or socks. He was not wearing his helmet. This behavior was documented.
- On Tuesday at approximately 9:45 pm, Individual #226 was observed attempting to clear a table top and hitting staff. These behaviors were not documented.
- On Tuesday at approximately 1:25 pm, Individual #537 was observed seated in his living room behind a privacy screen. He was not wearing his pants. This behavior was not documented.
- On Wednesday at approximately 10:50 am, Individual #198 was observed engaging in aggression while at the gym. One occurrence of aggression was recorded, but the Monitoring Team observed repeated aggression.

- On Wednesday at approximately 4:12 pm, Individual #242 was observed pacing, slapping the windows, and pushing his staff member. This agitated behavior was not documented.
- On Thursday, Individual #231 was seated in her living room. The BCBA explained that she had taken off her clothing. While staff had provided a blanket and a screen to protect her privacy, this is a behavior that is not appropriate in a group living situation. A check of her PBSP data sheet indicated that this behavior was documented when it occurred outside of her home. Staff are advised to track this behavior as well to ensure that appropriate assessments are completed and supports implemented to help reduce this behavior before it becomes a common pattern.

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

Summary: Performance was about the same as at the last review, though indicators 11 and 12 scored slightly lower. These indicators are ones that the Center, with some perhaps clerical support, could meet criteria by the time of the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 423	298	557	239	563	444	369	469	463
10	The individual has a current, and complete annual behavioral health update.	33% 3/9	1/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1
11	The functional assessment is current (within the past 12 months).	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
12	The functional assessment is complete.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1

Comments:

10. While all nine individuals had a behavioral health assessment that was current at the time of the document request, three were considered complete. These were the assessments for Individual #423, Individual #557, and Individual #469.

Several assessments (Individual #298, Individual #239, Individual #563, Individual #444, Individual #369, Individual #463) did not identify the assessment utilized to determine cognitive function or provide an intelligence quotient. Many of these same assessments (Individual #239, Individual #563, Individual #444, Individual #369) were missing information about the individual's physical health over the previous year.

Staff are advised to carefully proof all reports. In some cases, a different individual was named, the incorrect pronoun was used, or a schedule of reinforcement was labeled intermediate versus intermittent. It would also be helpful to identify nicknames or preferred names early in the report.

11. The functional behavior assessment was current for eight of the nine individuals. The exception was Individual #444 whose current functional behavior assessment was included in his behavior health assessment completed in July 2018. While a draft functional behavior assessment was presented at the Internal Peer Review Committee meeting held the week of the onsite visit, an

updated behavioral health assessment and functional behavior assessment should have been completed prior to this date.

12. The functional behavior assessment was considered complete for seven of the nine individuals. The exceptions were Individual #239 and Individual #369. Individual #239 was observed on two occasions, but did not exhibit any targeted problem behaviors. There was no explanation as to why additional observations were not necessary. It had been determined to cease documenting self-injurious behavior for Individual #369 due to its low rate of occurrence. However, it was reported that he had not been sleeping in his room since approximately 2016. This is a problem that should be addressed. Staff are advised to complete an assessment of this behavior, so supports can be identified and implemented. Additional feedback is provided below.

- The staff completing the functional assessment for Individual #298 are commended for scheduling observations during times when problem behavior was likely to occur as identified by familiar staff. It was also positive that the review of information obtained through staff interview included events/situations that were least likely to result in aggression or property destruction (i.e., maintenance of routine and access to leisure activities).
- For individuals who attended school, it would be advisable to conduct observations in this setting.
- Staff are advised to proof all reports to ensure that the information provided is current. For example, Individual #557's report indicated the assessment was being completed following his admission to the Center. He had been in residence for almost two years.
- When developing hypotheses regarding function, do not speculate about events that occurred prior to the individual's admission (e.g., stealing cars, breaking into homes), but that have not been observed at the Center. This would only be appropriate if a careful interview with family had been conducted (e.g., Individual #444).
- When completing Individual #563's assessment shortly after her admission, it would be advisable to interview her mother because staff were just getting to know her.
- Sensitivity should be applied when quoting previous assessments. For example, a report from 1989 was quoted in Individual #369's assessment. He was identified as a behavior problem who required a plan to address his aggression. The individual is not the problem and he no longer exhibited aggression. If historical information is referenced, it should be summarized in a manner that respects the individual.
- Individual #444's targeted behaviors were worsening and his overall presentation was reviewed repeatedly by the team, but there was no evidence in his progress notes of additional observations to update the functional assessment. Materials presented at the Internal Peer Review Committee meeting included an updated behavioral health assessment that described observations completed in April, May, and June 2019. This information should be documented in his progress reports. Staff should have been completing regular observations of Individual #444 throughout this time to ensure that the FBA was current and all appropriate supports were provided in a timely manner.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.												
Summary: Performance scores remained almost identical to the last review. Similar to outcome 3 above, with additional focus, the Center should be able to move these two indicators to meet criteria for all individuals by the time of the next review. They will remain in active monitoring.			Individuals:									
#	Indicator	Overall	423	298	557	239	563	444	369	469	463

		Score									
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	67% 6/9	0/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	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.	22% 2/9	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	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 #423, Individual #298, and Individual #369 whose plans were implemented prior to all necessary consents.

15. The PBSPs for Individual #557 and Individual #444 were considered complete. The majority of the remaining PBSPs included the following required elements: operational definitions of both targeted problem behaviors and replacement behaviors, antecedent and consequent strategies, and guidelines for training/strengthening functional replacement behaviors. It was particularly positive to review plans that included comprehensive reinforcement strategies.

Comments on individual PBSPs are provided below.

- Individual #423 - Her PBSP was very comprehensive. While most targeted problem behaviors were clearly operationalized, with several including non-examples, it would be advisable to clarify the definition of disruptive behavior because making fun of her peers was not sufficiently specific. There were multiple replacement behaviors; extensive antecedent strategies, including offering more time with preferred activities, advanced warning of upcoming activities, and assisting her in identifying conversational topics prior to calling her mother; a clear point system for reinforcing desirable behaviors; and clear consequences for responding to targeted problem behaviors. The plan did not include an objective for disruptive behavior, which resulted in a zero score for an otherwise very good PBSP.
- Individual #298 - His PBSP included reinforcement with a diner coupon for five days without problem behavior. It also focused on teaching him self-management skills through the completion of a worksheet at the end of each day time shift. This worksheet included the absence of vomiting, but this was not an identified target behavior. The criterion for a trip to dine out in the community appeared too strict because he was expected to display no targeted problem behavior for three months. It was unclear why there were guidelines for getting on the van. If he attempted to get on a van prior to exhibiting no problem behavior for 30 minutes, blocking pads were to be used. It would be advisable to measure this behavior if such intrusive measures are necessary. Lastly, it would be helpful if labels of problem behaviors were consistent throughout (e.g., elopement versus leaving without informing staff).
- Individual #557 - His PBSP was also quite comprehensive. Staff are commended for clearly outlining a point system and for including the offer of a safe place to relax as a preventative strategy to address elopement. Inappropriate urination had been added as a monitored behavior, so it would be helpful to provide an operational definition. It is also suggested that smearing fecal matter be added to the definition of disruptive behavior.
- Individual #239 - Disruptive behavior was defined as pushing or pulling, but it was unclear whether this was directed towards people or objects. Further, staff were to encourage Individual #239 to communicate his wants when he displayed precursor

behavior, including pulling staff, after which he could be given food or a preferred activity. This listing of pushing and pulling as both a target and precursor behavior was confusing and the response to this when considered a precursor could result in a strengthening of the behavior. Aggression and self-injury were identified as psychiatric indicators, but neither were defined or targeted for reduction. Further, there were guidelines for addressing self-injurious behavior and it was noted that he may display this behavior when he was feeling poorly. Individual #239 had a replacement behavior that involved his using a board to communicate what he wanted by pointing to a choice of photos/drawings. This board was not available to him at all times, rather he was first told to go get his board. As discussed with staff, if this is his means of communication, he should have access to it at all times. Staff were also advised to consult with the speech and language staff because they had identified a goal for Individual #239 to learn to use sign language. One consistent form of communicating should be identified, taught, and reinforced.

- Individual #563 - At the time of the document request, Individual #563 was being supported with a behavior protocol completed at her admission. By the time of the onsite visit, a PBSP had been developed. The following comments refer to this most recent plan. Regarding some of the preventative strategies, staff were to use verbal prompts to help reduce anxiety, but these prompts were not specified. Rather than telling her it was time for certain activities, staff were to ask her if she was ready. There were no guidelines for how staff should behave if she responded negatively. It was noted that she would respond "no thank you" when prompted to engage in a nonpreferred activity. As this is an appropriate form of communication, the prevention section should encourage staff to honor this response. Offering her a choice between two activities might also help mitigate problem behavior. While a token system was outlined, it was confusing because different token amounts were identified that would allow her to visit with behavioral health services three days weekly to exchange her tokens for preferred items.
- Individual #444 - It may be advisable to document his acceptance or refusal of each PNMP support separately. This would allow staff to focus on specific supports that are most frequently problematic.
- Individual #369 - When providing guidelines for training his replacement behavior, be sure to include a clear description of how staff will show this legally blind man the location of each offered object. This same replacement behavior was scheduled to be taught twice per shift, however, because the response was simply to reach for offered items, it would be advisable to implement more daily trials. There were no targeted behaviors identified in his PBSP, however, as reported by the home manager, Individual #369 had not slept in his room since approximately 2016. It would be appropriate to address this behavior.
- Individual #469 - His FBA referenced his inserting items into his rectum, but this was not addressed in his PBSP. Further, it was noted that, on occasion, fecal matter was found on items that he had taken from others. This would suggest that this behavior needs to be assessed and addressed in his plan. It was also reported that he was refusing meals. When information regarding action taken by behavioral health services was requested, staff reported that the IDT had not requested the tracking or support in addressing this behavior because it was considered a medical issue. Staff are advised to conduct observations during meal times to determine whether supports could be provided.
- Individual #463 - Her plan called for her to be offered lotion if she was scratching her arms (self-injury). This provided her with attention and access to a tangible item/activity, therefore, it would be preferable to offer lotion at regular intervals throughout the day rather than contingent upon self-injury.

The template used to complete PBSPs included two sections that could be misleading. The first was a list of *Monitored Behaviors* and

Psychiatric Indicators. While the expectation was that individual-specific behaviors would be noted with a check mark in the corresponding box, this was not always evident. If this section is to remain in the template, it would be helpful if instructions were included. The second section was entitled *Pro-social/Positive Behaviors to Maintain or Increase*. While staff explained that the same instructions applied here (i.e., check the behaviors that apply), this was not clear when reviewed independently. In general, it would be preferable to omit these standardized lists from the PBSP. Instead, staff are advised to list any psychiatric indicators, monitored behaviors, and positive outcomes that are specific to the individual.

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.											
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: Given that for three review periods, including this review, newly-admitted individuals reviewed had timely medical assessments (Round 9 – 100%, Round 10 – N/A, Round 11 – 100%, Rounds 12 to 14 – N/A, and Round 15 - 100%), Indicator a will move to the category requiring less oversight. Since the last review, improvement was noted with regard to the timeliness of annual medical assessments. Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	than 365 days.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." 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: Center staff should continue to improve the quality of the medical assessments with particular focus on the inclusion of thorough plans of care for each active medical problem. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	Individual receives quality AMA.	44% 4/9	1/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	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 four individuals' AMAs (i.e., Individual #469, Individual #100, Individual #383, and Individual #406) included all of the necessary components, and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, family history, social/smoking histories, childhood illnesses, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included, as applicable, past medical histories, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include thorough 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 #469 – infections, and gastrointestinal (GI) problems; Individual #563 – falls, and weight; Individual #100 – fluid imbalance, and respiratory compromise; Individual #150 – falls, and weight; Individual #383 – cardiac disease, and fractures; Individual #406 – GI problems, and urinary tract infections (UTIs); Individual #411 – GI problems, and falls; Individual #425 – diabetes, and UTIs; and Individual #382 – GI problems, and other: pica].

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. Moreover, for the individuals reviewed, PCPs generally did not complete IMRs. Occasionally, individuals had them completed at six-month intervals, which was not adequate, given their high-risk conditions.

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, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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.	11% 2/18	2/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #469 – infections, and GI problems; Individual #563 – falls, and weight; Individual #100 – fluid imbalance, and respiratory compromise; Individual #150 – falls, and weight; Individual #383 – cardiac disease, and fractures; Individual #406 – GI problems, and UTIs; Individual #411 – GI problems, and falls; Individual #425 – diabetes, and UTIs; and Individual #382 – GI problems, and other: pica). 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 #469 – infections, and GI problems. b. For the risk areas reviewed, IDTs had not included action steps in IHCPs defining 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: Due to the Center's sustained performance in providing newly admitted individuals with timely dental exams and summaries (i.e., Round 9 – 100%, Round 10 – N/A, Round 11 - 100%, Rounds 12 to 14 – N/A, and Round 15 - 100%), and the quality of annual dental summaries (i.e., Round 13 – 89%, Round 14 - 100%, and	Individuals:

Round 15 - 89%), Indicators a.i and c will move to the category requiring less oversight. For most of the individuals reviewed, comprehensive dental examinations included all of the required components, and the remaining exams reviewed included most of the required components. If the Dental Department sustains the progress it has made with regard to the quality of dental exams over time, after the next review, Indicator b might move to the category requiring less oversight.											
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	Due to the Center's sustained performance with these indicators, they have moved to the category of requiring less oversight.									
	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.	78% 7/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: a. For the one individual who was newly admitted, Center staff completed a dental examination and summary within 30 days of admission.

b. It was positive that for seven of 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.

For the remaining two individuals, the dental examinations met most, but not all, of the required components. For Individual #469, dental staff did not document that an oral hygiene rating was completed prior to treatment. For Individual #150, the Center did not complete periodontal charting, and although the dentist provided the reason (i.e., insufficient cooperation to safely/effectively probe today), the dentist did not describe the plan to complete the periodontal probing (e.g., recall on another day, complete during TIVA, etc.). This individual's last periodontal type was listed as Periodontal Disease Type I.

c. It was good to see that for eight of the nine individuals reviewed, the dental summaries included all of the required components, including 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.

For Individual #469, the dental summary did not provide complete written oral hygiene instructions.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: For the nine individuals reviewed, nurses completed timely annual or new-admission nursing reviews and physical assessments. They also completed timely quarterly nursing record reviews and/or physical assessments for the eight individuals needing them. If the Center sustains this performance, after the next review, Indicators a.i though a.iii might move to the category requiring less oversight. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall	469	563	100	150	383	406	411	425	382

		Score									
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: a.i. and a.ii. It was good to see that for the nine individuals reviewed, nurses completed timely new admission or annual and quarterly nursing reviews and physical assessments.											

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: It was positive that for 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.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

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% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	6% 1/16	0/2	N/A	0/2	0/2	1/2	0/2	0/2	0/2	0/2
g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	50% 3/6	0/2	N/A	1/1	N/A	1/1	N/A	1/1	0/1	N/A

Comments: a. It was positive that all of the annual or new-admission nursing record reviews the Monitoring Team reviewed included, as applicable, the following:

- Active problem and diagnoses list updated at the time of annual nursing assessment (ANA);
- Social/smoking/drug/alcohol history;
- List of medications with dosages at the time of the ANA;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Allergies or severe side effects to medication.

Most, but not all included, as applicable:

- Family history; and
- Tertiary care.

The components on which Center staff should focus include:

- Procedure history; and
- Immunizations.

b. It was positive that for the nine individuals reviewed, nurses completed new admission or annual physical assessments that addressed the necessary components.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #469 – choking, and falls; Individual #563 – cardiac disease, and weight; Individual #100 – dental, and seizures; Individual #150 – weight, and skin integrity; Individual #383 – respiratory compromise, and seizures; Individual #406 – respiratory compromise, and seizures; Individual #411 – GI problems, and cardiac disease; Individual #425 – diabetes, and infections; and Individual #382 – choking, and GI problems).

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 third of the risk areas reviewed, nurses included status updates in annual assessments, including relevant clinical data (i.e., Individual #469 – falls; Individual #100 – dental, and seizures; Individual #383 – seizures; and Individual #411 – GI problems, and cardiac disease). Unfortunately, nurses had not analyzed this information (i.e., the only exception was for Individual #383 – seizures), 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.

In its comments on the draft report, the State requested clarification with regard to the finding related to the final sentence of the paragraph above, and cited certain individuals' annual nursing record reviews that they believed met criteria. The following provide some additional comments regarding the concerns noted:

- Based on a review of the specific risk areas identified above for the nine individuals the Monitoring Team reviewed, often, nurses included very little to no analysis of data or information related to the individuals' status. In other words, although at times, nurses listed information that might be relevant to the individual's status (e.g., oral hygiene ratings, quotes from psychiatric clinics or PCP reports, numbers of infections, weights, etc.), they frequently did not summarize this information in a concise format that told the IDT whether or not the individual was doing better, regressing/doing worse, or remained the same from the previous year or quarter.
- Due to issues with dates as well as content, it often was difficult to follow individuals' clinical stories. For example, summaries often said "for this quarter," when it appeared that the information cited actually was from previous quarters. Often, this seemed to be due to nurses cutting and pasting from previous reviews without updating the content or fixing grammar.
- Important parts of the analyses that were consistently missing were the identification of the underlying cause(s) of the individual's risk, as well as then recommendations to address such causes/issues, and updates and analysis of the strategies in place to address the risk areas. In other words, if the individual was not progressing, then nurses needed to answer the questions of whether or not staff had implemented supports that in the IHCP, and whether or not they were working,/effective and if not, to make recommendations about needed modifications to the supports. For example:
    - For Individual #469, the nurse noted that his oral hygiene remained poor, and he had not met his goal (which was not clinically relevant or measurable). The nurse provided no information about what the planned interventions were to help the individual improve his oral hygiene and/or whether or not staff implemented them. However, the nurse then concluded: "[Individual #469] has at times can have [sic] poor cooperation with hygiene that could increase dental issues." In addition to no data or analysis about the implementation and/or effectiveness of the current supports, the nurse offered no insights into or recommendations regarding what was needed to increase the individual's cooperation and/or otherwise decrease his risk.

- For Individual #150, the nurse concluded that she "has remained above her recommended weight range of 108-132 Lbs. this quarter with her weight being 150 pounds." The only reference to a possible cause was "While her base diet calorie level is low, she receives additional calories from preferred snack items, prune juice, Fiber-Stat and reinforcers." The nurse provided no specifics about the individual's intake, including for example, specifics about the reinforcers she received to provide an understanding of what portions of her diet were most influencing her inability to lose weight. In addition, the nurse provided no information about what strategies currently were included in the individual's IHCP to address her need to lose weight, whether they had been implemented, and/or whether they needed revision. Beyond diet, the nurse provided no indication of what other factors might impact her weight or weight loss, such as exercise, including specific data to help determine whether recommendations were needed in other areas.

Individual #383's quarterly assessment related to her seizures met criteria, which is reflected in the score of "1" for Indicator f. For the following risk areas nurses included necessary status updates, including relevant clinical data in the most recent quarterly assessment: Individual #469 – choking, and falls; Individual #100 – dental, and seizures; Individual #383 – seizures; and Individual #411 – GI problems, and cardiac disease.

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

- Active problem and diagnoses list updated at the time of the quarterly assessment;
- Social/smoking/drug/alcohol history;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Consultation summary;
- Tertiary care; and
- Allergies or severe side effects to medication.

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

- Family history; and
- Lab and diagnostic testing requiring review and/or intervention.

The components on which Center staff should focus include:

- Procedure history; and
- Immunizations.

e. Individual #563 was newly admitted, and was not yet due for a quarterly physical assessment. It was positive that for the other eight individuals reviewed, nurses completed quarterly physical assessments that addressed the necessary components.

g. On a positive note:

- On 1/12/19, at 7:46 a.m., Individual #411 complained of not feeling well and loose stools. A nurse conducted an abdominal assessment. assessment that was consistent with the relevant guideline and the individual's symptoms. Staff also obtained a stool specimen. Based on a positive hemoccult, the individual was admitted to the Infirmary. His leukocytosis was treated with Rocephin, and resolved on 2/19/19.
- On 2/26/19, Individual #100 experienced a series of four seizures. Based on review of IPNs and IView entries, the nurse

conducted assessments in alignment with the seizure guidelines.

- On 4/12/19, at 3:50 a.m., Individual #383 vomited twice followed by a 45-second seizure. At 6:29 a.m., she had another seizure while in bed. Nurses conducted assessments in alignment with the seizure guidelines, and the individual was sent to the Infirmary.

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

- For Individual #469, a change-of-status IRRF indicated that the IDT increased his risk for choking to high. However, nursing assessments were not cited/found to support this change of status.
- On 6/12/19 at 6:30 p.m., Individual #469 was found sitting on the bedroom floor not wearing any clothes, and he was described as hyperalert with labored breath sounds. The nurse completed an assessment, including a pain assessment, level of consciousness assessment, and fall information. However, although the individual was placed on 24-hour monitoring, no further assessments were documented until 6/13/19, at 6:38 a.m. At that point, nursing staff initiated the fall nursing assessment guideline for 24 hours. On 6/13/19, at 7:20 a.m. and 7:35 a.m., nursing notes addressed swelling to the individual's left foot.
- On 1/23/19, at 7:18 p.m., staff reported redness and swelling on Individual #425's left elbow. IView entries included a pain score of 0, vital signs, and oxygen saturation rates. The plan was to refer the individual to the home's RN, and to arrange for the PCP to conduct an assessment. It was not until 1/24/19, at 8:20 a.m., that a nurse wrote an addendum addressing staff's report of redness to the left elbow. A note dated, 1/24/19, at 9:42 a.m., indicated that the PCP called back to have him brought to the treatment room after lunch. While an assessment was completed, the plan was not consistent with guidelines and treatment was not obtained timely.

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

Summary: Given that over the last several review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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.	11% 2/18	0/2	0/2	1/2	0/2	0/2	1/2	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	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	plan is working).										
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. Individual #100's IHCP for seizures and Individual #406's IHCP for aspiration included some preventative interventions (e.g., clear description of the use of the vagus nerve stimulator, lung sound assessments).

Overall, the IHCPs reviewed were missing key nursing supports. For example, RN Case Managers and IDTs generally had not individualized interventions in relevant nursing guidelines and included in the action steps of IHCPs specific assessment criteria for regular nursing assessments at the frequency necessary to address conditions that placed individuals at risk [e.g., if an individual was at risk for skin breakdown/issues, then an action step(s) in the IHCP that defines the frequency for nursing staff to assess the color, temperature, moisture, and odor of the skin, as well as the drainage, location, borders, depth, and size of any skin integrity issues]. At times, IDTs had included nursing physical assessments, but had not defined the frequency, which should be individualized to address the individual's needs and level of risk.

In its comments on the draft report, the State disputed the statement about the lack of measurability, and indicated that: "Within an individual's IHCP, assessment frequency is specifically noted at the beginning of each intervention with the abbreviations of (M) Monthly, (Q) Quarterly, (W) Weekly, (A) Annually. See TX-AB-1908-II.03. a, p. 4 as an example; 'Intervention: N (M) Review any physical or chemical restraints required." To clarify, in conducting the review, the Monitoring Team member figured out what the initials meant. As discussed recently with State Office staff, the use of unapproved abbreviations is problematic, particularly in Centers that rely on agency nurses. That being said, the Monitoring Team understands that due to the limitations with IRIS, nurses often use abbreviations in an attempt to overcome issues such as character limitations. To explain the issues with measurability further, because interventions did not specify specific days of the week or month, shifts, etc., they were not fully measurable. This made it unclear how staff were to know when to implement them, and/or how from a supervisory and/or auditing perspective implementation would be tracked. In addition, interventions did not consistently describe the parameters for assessments consistent with applicable nursing guidelines/standards of care. All of that being said, it was positive to see that many RN Case Managers and IDTs had attempted to include one or more nursing intervention for ongoing assessments in many of the the IHCPs reviewed.

In addition, often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause or etiology of the at-risk or chronic condition (e.g., if an individual had poor oral hygiene, a nursing intervention to evaluate the quality of the individual's tooth brushing, and/or assess the individual's oral cavity after tooth brushing to check for visible food; if an individual's positioning contributed to her aspiration risk, a schedule for nursing staff to check staff's adherence to the positioning instructions/schedule; if an individual's weight loss was due to insufficient intake, mealtime monitoring to assess the effectiveness of adaptive equipment, staff adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.). Significant work is needed to include nursing interventions that meet individuals' needs into IHCPs.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: The PNMT did not conduct reviews or assessments for a number of individuals reviewed that met criteria for PNMT involvement. Of significant concern, the PNMT appeared to defer formal reviews to the IDTs with the explanation that the IDT had not yet had time to and/or developed plans to address the PNM issue. It is essential to understand that at the point an individual meets criterion for PNMT involvement, a threshold has been crossed that requires external review of the IDT's work (i.e., a second opinion). As such, the PNMT needs to conduct at least a formal review, and when necessary, a formal assessment to the depth and complexity necessary to meet the individual's needs. The PNMT also often concluded that the "root cause" of the PNM issue had been previously identified, when sufficient investigation of true "root causes" had not occurred. This showed a lack of understanding of "root cause analysis." In other words, true analysis of the underlying etiology would require further inquiry into "why": for example, why the small bowel obstruction that might have been a cause of aspiration pneumonia occurred, including inquiring about factors such as positioning, activity level, fluid intake levels, fiber intake, etc., etc. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	78% 7/9	2/2	N/A	2/2	0/1	1/1	1/1	0/1	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	11% 1/9	0/2		0/2	0/1	1/1	0/1	0/1	0/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/1	N/A		N/A	0/1	N/A	N/A	N/A	N/A	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	33% 3/9	0/2		0/2	0/1	1/1	1/1	0/1	1/1	

e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	25% 1/4	0/1		0/2	N/A	N/A	N/A	1/1	N/A	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/9	0/2		0/2	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.	13% 1/8	0/2		0/2	N/A	1/1	0/1	0/1	0/1	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/1	N/A		N/A	0/1	N/A	N/A	N/A	N/A	

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

- For Individual #469's pneumonia on 6/5/19, the PNMT did not conduct a review. A PNMT note, dated 6/26/19, stated that the PNMT would not provide a review due to hospital information not providing enough information about the types of pneumonia, but indicating it was possibly bacterial pneumonia, and the individual did not have a history of other pneumonias over the past year. The PNMT did not conduct observations due the individual not having dysphagia or a history of aspiration pneumonia. However, in order to ensure supports were effective, the PNMT should have conducted at least a review, given that aspiration pneumonia had not been ruled out, and over the last several months, he had been hospitalized several times for respiratory-related illnesses and/or suspected sepsis (i.e., on 3/25/19, to rule out sepsis and possible pneumonia; on 4/14/19, for respiratory distress, abdominal distention, vomiting and hypoxia; on 5/3/19, for possible sepsis; and on 6/5/19, for fever and sepsis). Additionally, Individual #469 was known to not follow his prescribed thickened liquid consistency, and at times, drank thin liquids (e.g., on 3/5/19), as per QIDP monthly note, dated, 7/1/19. For this individual's hospitalization, the RN Post-Hospitalization was missing key information, such as the date of admission.

  On 7/11/19, the IDT referred Individual #469 to the PNMT for emesis. Based on information provided in Document #TX-AB-1908-II.P.1-20, between 3/23/19, and 7/8/19, the individual experienced 14 episodes of emesis. However, according to a PNMT note, dated 7/11/19, the PNMT did not conduct a review, because the suspected cause for the emesis was a UTI. The PNMT should have conducted at least a review to determine whether or not outlined supports were implemented and effective. In addition, it was not clear that the cause of the emesis had been established. For example, at the time of the Monitoring Team's review, a gastric emptying study and upper GI series were pending.
- Based on review of IPNs, on 10/26/18, Individual #100 met criteria for referral to the PNMT due to a small bowel obstruction. The PNMT stated that they would complete a review and report findings, but they did not complete a review. Almost

immediately, the individual was re-admitted to the hospital. Upon his return to the Center, on 11/15/18, the PNMT stated that oversight was no longer needed, because the aspiration was caused by the small bowel obstruction, which the PCP was addressing with increased bowel management. A PNMT review was still warranted with findings from the PCP's plan integrated. The PNMT should have, for example, conducted observations related to positioning, as well as reviewed other factors that could impact emesis, constipation, and aspiration. Of note, on 2/10/19, Individual #100 was diagnosed again with a bowel obstruction, and between 1/3/19 and 7/28/19, he experienced at least 29 episodes of emesis (i.e., according to Document #TX-AB-1908-II.P.1-20). In addition, between October 2018 and 7/6/19, he had eight respiratory-related illnesses/hospitalizations, which resulted in repeated assaults on his lungs. It was not until June 2019, that the PNMT even conducted a review (i.e., referral date 6/21/19). In addition, despite ongoing issues, it was not until 6/11/19, that results from a GI workup were noted. At that point, they identified the individual had a J-shaped stomach, which required increased elevation. When all of the issues began in October 2018, involvement of the PNMT should have resulted in discussion and trials of increased elevation.

- Individual #150 had a significant history of falls. For example, in 2016, she experienced six falls; in 2017, she fell 42 times, in 2018, she fell 79 times; and between January 2019 and August 2019, she experienced over 200 falls. In October 2018 and November 2018, the individual's falls met the PNMT threshold. Although PNMT members made multiple notes, the PNMT did not complete a review. On 11/30/18, the PNMT referred the individual back to the IDT for a "root cause" analysis. It was unclear why, at this juncture, the PNMT did not complete an assessment. It was not until 1/18/19, that the PNMT conducted a review (i.e., referral on 1/9/19). The PNMT should have conducted a full assessment.
- On 5/3/19, Individual #383 was diagnosed with a non-displaced fracture of the right lateral malleolus. Her IDT referred her, and on 5/13/19, the PNMT conducted a review. It was good to see that the review included the required components and addressed the individual's needs.
- According to Document #TX-AB-1908-II.P.1-20, between 1/15/19, and 7/18/19, Individual 406 had 57 episodes of emesis. Of these, 43 were identified as "self-induced." On 2/14/19, and 6/27/19, the PNMT made self-referrals. On 2/25/19, and 7/8/19, the PNMT reviewed her. The causes for the delays were not documented. The review, dated 2/25/19, lacked discussion regarding assessment of positioning and/or elevation, and/or time sitting up after G-tube feedings. Despite data submitted to the Monitoring Team as part of Document #TX-AB-1908-II.P.1-20 indicating that some of the individual's emesis prior to this review was not self-induced, the PNMT discharged the individual stating that: "PNMT assessment is not warranted at this time, as all of her episodes of emesis were self-induced and behavioral in nature. She has a behavior protocol in place that tracks self-induced emesis as disruptive behavior." Based on the list of participants, no Behavioral Health Services (BHS) staff participated in this review.

  Moreover, the review, dated 7/18/19, indicated that on 5/23/19, she had an EGD, and that: "One likely root cause for [Individual #406] was her diagnosis of ulcerative Esophagitis without active bleeding and minimal gastritis… It is also very likely there is a behavioral root cause for her self-induced emesis; whether this is driven by pain or another reason has yet to be determined; however, it can not be denied that her emesis is frequently observed to be self-induced." Again, no BHS staff were listed as participants, nor was a PCP/provider listed. The PNMT concluded that: "Due to the most likely dual cause of medical and behavioral factors leading to repeat emesis, PNMT recommends an RCA ["Root Cause Analysis"] be conducted with both medical and behavioral staff present." Again, given the long history of the emesis, and the new diagnosis of ulcerative esophagitis, the review lacked discussion regarding assessment of positioning and/or elevation, and/or time sitting up after G-

tube feedings. It also was unclear why the PNMT did not work with the IDT to identify the underlying cause(s).

- In response to Individual #411's diagnoses of aspiration pneumonia and small bowel obstruction, on 4/14/19, the PNMT did not conduct a review. According to PNMT minutes, dated 4/23/19, the PNMT concluded that a review was not needed, because the "root cause" of the pneumonia was the small bowel obstruction, and the PCP prescribed Docusate Senna. A PNMT full review was still warranted as opposed to only a review of the medication. For example, the PNMT should have reviewed other relevant supports, such as positioning, the individual's intake of fluids, as well as his active mobility, such as walking, all of which are areas that can impact these risk areas. In other words, the PNMT had not asked enough "why questions?" to determine the possible underlying cause(s) for the small bowel obstruction and/or the pneumonia. According to the ISPA, dated 4/10/19, this individual had a significant history of aspiration pneumonia (i.e., on 10/14/18, 12/27/18, 3/9/19, and this event on 4/14/19).
- Based on Document #TX-AB-1908-II.P.1-20, between 2/13/19, and 7/24/19, Individual #425 fell 39 times. On 6/20/19, the IDT referred him to the PNMT. It was not until 7/1/19 that the PNMT completed the review. Some of the problems with the PNMT review included that the section on the potential impact on PNM needs was vague and did not fully address the issue. For example, it did not state that due to the increasing falls, his risk of fractures was increased. The PNMT identified his vision as the primary cause of his falls, but offered no recommendation or discussion of the involvement of an Orientation and Mobility (O&M) specialist, or how this information impacted gait safety.

In its comments on the draft report, the State disputed many of the findings above. The Monitor reviewed the State's comments in detail and made no substantive changes to the original findings. As these findings illustrate, many individuals at the Center have unmet PNM needs. The Monitoring Team encourages the Center Administration to consider steps that the PNMT needs to take to improve the supports and services it provides to identify the underlying causes of individuals' PNM needs, and work with IDTs to develop and implement supports responsive to those needs. In order to make this possible, further training for PNMT members might be needed to assist them in completing thorough analyses, identifying underlying cause(s), developing interventions to address them, setting out goals/objectives to assist in determining whether or not the interventions are effective in addressing the suspected causes, and using data to determine whether or not changes to the interventions are needed.

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

h. As noted above, Individual #150 should have had comprehensive PNMT assessments, but did not.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. In some cases, IDTs had included a number of necessary PNM interventions in individuals' ISPs/IHCPs. However, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual 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.	28% 5/18	2/2	0/2	1/2	0/2	0/2	1/2	0/2	0/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	29% 5/17	1/2	1/2	0/2	1/2	0/1	0/2	0/2	0/2	2/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	67% 12/18	1/2	2/2	0/2	2/2	2/2	2/2	0/2	1/2	2/2

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 #469 - aspiration, and GI issues; Individual #563 – falls, and choking; Individual #100 – constipation/bowel obstruction, and aspiration; Individual #150 – choking, and falls; Individual #383 – choking, and falls; Individual #406 – aspiration, and GI issues; Individual #411 – falls, and aspiration; Individual #425 - aspiration, and falls; and Individual #382 – aspiration, and choking.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks. In some cases, IDTs had included a number of necessary PNM interventions in individuals' ISPs/IHCPs. However, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps (e.g., if behavior was a frequent cause of falls, measurable interventions to address the behaviors should be included; or

if an individual was at increased risk of choking due to a fast eating pace or improper positioning during meals, then measurable action steps are needed to address these factors).

c. All individuals reviewed had PNMPs and/or Dining Plans. Four of the PNMPs were in the new format that State Office recently rolled out (i.e., for Individual #563, Individual #383, Individual #406, and Individual #382). None of the PNMPs reviewed fully met the individuals' needs. Problems varied across the PNMPs and/or Dining Plans reviewed.

- It was positive that Habilitation Therapy staff had reviewed and/or updated the plans within the last 12 months, and that all of the PNMPs, as applicable to the individuals' needs included:
  - Photographs;
  - Transfer instructions;
  - Bathing instructions;
  - Toileting/personal care instructions;
  - Handling precautions or moving instructions;
  - Mealtime instructions;
  - Medication administration instructions; and
  - Oral hygiene instructions.
- As applicable to the individuals, most, but not all of the PNMPs reviewed:
  - Mobility instructions that reflected the individual's current needs. In its comments on the draft report, the State requested further information. Individual #150's PNMP included mobility instructions that indicated she was primarily "independent," secondarily "ambulates with gait belt and 1 staff when unable to walk on her own or unsteady," and thirdly used a "wheelchair for out of home activities and long distance transport." Given the number of times she had fallen, more definition was needed beyond "unsteady" to guide staff when providing supports.
- The components of the PNMPs on which the Center should focus on making improvements include:
  - Some of the PNMPs/Dining Plans were missing medium risk levels, and/or the triggers listed were not tied to risk levels;
  - In some plans (i.e., using the new format), assistive/adaptive equipment was listed in its own section, but not included in applicable sections providing instructions to staff (e.g., related to positioning). Clinicians need to provide direct support professionals with information about when/how to use adaptive equipment;
  - Positioning instructions; and
  - Complete communication strategies.

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 #469 - aspiration, and GI issues; Individual #100 – aspiration; Individual #406 – aspiration; and Individual #382 – aspiration.

f. The IHCPs that identified triggers and actions to take should they occur were those for: Individual #469 - aspiration; Individual #563 – choking; Individual #150 – choking; and Individual #382 – aspiration, and choking.

g. Similar to the last review, a number of the IHCPs reviewed included descriptions of the necessary PNMP monitoring, including the frequency. Those that did were for: Individual #469 - GI issues; Individual #563 – falls, and choking; Individual #150 – choking, and falls; Individual #383 – choking, and falls; Individual #406 – aspiration, and GI issues; Individual #425 – falls; and Individual #382 – aspiration, and choking. To move forward, IDTs need to make sure to include the frequency of monitoring needed.

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	469	563	100	150	383	406	411	425	382
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	100% 1/1	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	N/A			N/A			N/A			
Comments: a. and b. For the two applicable individuals, the IDTs provided justification for continued enteral nutrition in their IRRFs/IHCPs. Movement along the continuum to oral intake was not appropriate for either Individual #100, or Individual #406.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments has varied. For this review, timeliness for the annual ISP did not appear to be a significant concern, but OT/PT staff frequently failed to complete other needed assessments. While it was positive to see some improvement, the quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual	100%	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	receives a timely OT/PT screening or comprehensive assessment.	1/1									
	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.	67% 6/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	50% 3/6	N/A	1/1	0/1	0/1	N/A	1/1	N/A	0/1	1/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	33% 1/3	0/1	N/A	N/A	N/A	1/1	N/A	0/1	N/A	N/A
Comments: a. and b. Two of the six individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted: • Individual #100 had ongoing issues with emesis, and respiratory problems. It was not until 6/11/19, which was eight months											

after the issues began, that Habilitation Therapy staff conducted a head-of-bed elevation (HOBE) evaluation.

- For Individual #150, the Center did not submit evidence of an assessment that included trials to increase the use of a gait belt or of a formal or informal program to address gait issues and safety. An assessment, dated 3/27/19, stated that the gait belt did not work, and that OT/PT staff felt that ambulation devices would not work, but did not document an assessment that included trials or attempts as evidence for these conclusions.
- The guardian for Individual #425 expressed concern about his ability to coordinate breathing and swallowing functions. On 6/26/19, the Center OT provided a consult, and stated the individual had a weak cough and decreased rotary chew and that the Center Speech Therapist would complete an additional assessment. Based on the documentation submitted for review, Center staff did not complete this additional assessment. In addition, the IDT did not clearly document consideration of Individual 425's need for a specialized orientation and mobility assessment due to his vision deficits and the resulting impact on his risk for falls.

  In its comments on the draft report, the State disputed this finding, and stated: "Individual #425 was assessed by OT 6/24/19 (note dated 6/26/19 (See TX-AB-1908-II.100.h, p.34) [sic]. OT/SLP did complete the additional assessment which is documented in a Progress note dated 8/8/19 (this progress note was outside the document request dates and was not requested on site by the SAMT). The facility is willing to provide this progress note." If Center staff completed an assessment on 8/8/19, it was seven weeks after the identification of potential problems with the individual's oral motor skills, which was not timely given the potential risk to the individual. Moreover, it was after the Monitoring Team provided the Center with the list of individuals that it planned to review.

d. It was positive that the assessments for Individual #563, Individual #406, and Individual #382 met criteria for a quality assessment. It was also positive that the remaining comprehensive assessments reviewed met criteria, as applicable, with regard to:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living; and,
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale.

As applicable, most, but not all met criteria with regard to the following sub-indicators:

- The individual's preferences and strengths were used in the development of OT/PT supports and services; and
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

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

- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and,
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and

positioning supports), including monitoring findings; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

e. It was positive that Individual #383's assessment included all of the necessary components, and met her needs. It also was good to see that all of the updates reviewed 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;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale); and,
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings.

The Center should focus most on the following sub-indicators:
- 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;
- 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: Indicator b is at risk of returning to active oversight. Although, at times, IDTs discussed needed changes to PNMPs in ISPAs, at the time of annual ISP meetings, IDTs generally did not document discussions of needed changes. Improvement continued to be needed with regard to the remaining indicators as well. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.	Individuals:

#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	Due to the Center's sustained performance with this indicator, it has moved to the category of requiring less oversight. However, this indicator is at risk of returning to active oversight. Although, at times, IDTs discussed needed changes to PNMPs in ISPAs, at the time of annual ISP meetings, IDTs generally did not document discussions of needed changes.									
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	38% 3/8	0/2	N/A	N/A	1/1	N/A	1/1	0/1	0/2	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.	33% 2/6	0/2	N/A	1/1	N/A	1/1	0/1	0/1	N/A	N/A

Comments: a. Most of the ISPs reviewed for this indicator included concise, but thorough descriptions of individuals' OT/PT functional statuses. The exceptions were for Individual #469, and Individual #100 whose ISPs lacked a cohesive statement with regard to their overall functioning in this area.

b. Indicator b is at risk of returning to active oversight. Although, at times, IDTs discussed needed changes to PNMPs in ISPAs, at the time of annual ISP meetings, IDTs generally did not document discussions of needed changes.

c. and d. The following provides examples of concerns noted:

- The IDT for Individual #469 did not include his recommended interventions in ISP/ISPA action plans.
- Although it had been recommended in the OT assessment for Individual #411, the IDT did not provide evidence that Center staff had implemented training with a reacher so that he might avoid leaning over in his chair and causing it to tip.
- Individual #425's IDT included broad action plans for direct therapy in his ISP/ISPA, but did not integrate his specific and individualized goals.
- For Individual #406, no evidence was found to show the IDT met to discuss the need to float the heel due to skin breakdown.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Overall, timeliness of assessments had improved. However, significant work is needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to 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.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	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.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of:	N/A									

	▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	N/A	0/1	0/1	N/A	N/A	0/1	N/A	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/4	0/1	N/A	N/A	0/1	0/1	N/A	0/1	N/A	N/A

Comments: a. For Individual #563, the Speech Therapist did not complete the annual communication assessment until two days before the ISP date of 6/20/19.

d. Assessments continued to need significant work. Overall, they did not consistently reflect strategies to help improve success and/or participation in other skill acquisition plans (SAPs), and/or review the effectiveness of the current supports and services provided; they often lacked adequate exploration regarding how to expand individuals' skills through the use of various alternative and AAC and EC devices/systems; and, did not recommend communication plans or goals for individuals with higher level skills that would support those needs.

It was positive, though, that all five comprehensive assessments reviewed met criteria, as applicable, with regard to the following sub-indicators:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A comparative analysis of current communication function with previous assessments; and,
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated.

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 functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- 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;
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and

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

e. It was positive that all four updates reviewed met criteria, as applicable, with regard to discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication. Most also met criteria for 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; and,
- 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;
- Analysis of 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;
- 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: To move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals' communication supports in ISPs. Indicators b through d will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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 with this indicator, it has moved to the category of requiring less oversight.									
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs)	90% 9/10	1/1	1/1	1/2	1/1	1/1	1/1	1/1	1/1	1/1

	recommended in the assessment.										
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. Overall, based on a review of the documentation, most Communication Dictionaries lacked information regarding individuals' receptive skills. In addition, for Individual #382, the Communication Dictionary stated staff should use objects to help her understand, but this was in conflict with the communication assessment, which stated that she did not attend to objects. IDTs should ensure their review of the Communication Dictionaries identify and resolve such discrepancies.

c. Overall, it was concerning that most individuals did not have recommendations for strategies, interventions and programs included in their assessments beyond communication strategies in their PNMPs. While it was good that IDTs did include those strategies in individuals' PNMPs, many communication needs remained unaddressed. Only two individuals had a recommendation for something other than communication strategies, and only one of these was included in the individual's ISP/ISPA. For Individual #425, the IDT did include the recommended support (i.e., use a script to make a phone call), but for Individual #563, the IDT did not include the recommended support (i.e., continued assessment for AAC).

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: One-third of individuals had two SAPs and probably could have benefited from having more than two. About the same percentage of SAPs were based on assessment results and were practical/functional/meaningful as at the last review. This should be improved. It was good to see that most SAPs (about three-fourths) had reliable data. These three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463
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.	42% 10/24	0/2	0/2	0/3	1/3	1/2	1/3	3/3	2/3	2/3
4	SAPs are practical, functional, and meaningful.	42% 10/24	0/2	0/2	1/3	1/3	1/2	1/3	1/3	3/3	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	77% 17/22	2/2	0/2	2/3	3/3		2/3	3/3	2/3	3/3

Comments:

1-2. All of the individuals had Skill Acquisition Plans (SAPs). Three SAPs were reviewed for each of six individuals. The exceptions were Individual #423, Individual #298, and Individual #563 who each had two SAPs. Of the 24 SAPs that were reviewed, all were measurable.

3. Ten of the 24 SAPs were based on either the Functional Skills Assessment (FSA) or the current performance level reported in the SAP. These were the following: Individual #239 - pass ball; Individual #563 - rinse hair; Individual #444 - cut food; Individual #369 - pedal cycle, sign more, and get cup; Individual #469 - stamp pad and brush teeth; and Individual #463 - phone call and put on shirt.

For the other 14 SAPs, either:

- the assessment indicated the individual could perform the skill (e.g., Individual #239 - seat belt, Individual #563 - phone call),
- the person could perform the skill with different materials or with accommodations (e.g., Individual #557 - multiplication, Individual #444 - set timer), or
- there was no baseline assessment of the identified skill (e.g., Individual #423 - money, Individual #557 - worksheets, Individual #469 - mail card).

4. Ten of the 24 SAPs were considered practical, functional, and/or meaningful. These were the following: Individual #557 - worksheets; Individual #239 - pass ball; Individual #563 - rinse hair; Individual #444 - cut food; Individual #369 - get cup; Individual #469 - stamp and mail card, brush teeth; and Individual #463 - phone call, put on shirt.

All others were either skills the individual had already mastered; skills that did not address the identified goal; or skills that could be more readily learned with accommodations.

5. Seventeen of 22 SAPs had been monitored by the Center and were found to have acceptable data reliability in the last six months.

The exceptions were the following: Individual #298 - complete application and complete withdrawal form; Individual #557 - critical thinking worksheets; Individual #444 - set timer at work; and Individual #469 - stamp card. It should be noted that the two SAPs for Individual #563 were excluded from this analysis as they had not yet been implemented for three months.

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 improved to 100% for the timeliness of completion and submission of these assessments. Performance worsened in that some individuals did not have a vocational assessment, but should have (indicator 10). Also, performance worsened in that vocational and day assessments did not include recommendations for SAPs (FSAs, however, did include recommendations for SAPs). These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 423	298	557	239	563	444	369	469	463

10	The individual has a current FSA, PSI, and vocational assessment.	56% 5/9	0/1	1/1	0/1	1/1	0/1	1/1	1/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	33% 3/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1

Comments:

10. All nine individuals had a current Functional Skills Assessment (FSA) and Preferences and Strengths Inventory (PSI). However, only three individuals (Individual #298, Individual #239, Individual #444) had a vocational assessment. Regarding the others:

- Because they were still of working age, vocational assessments should have been completed for Individual #423 and Individual #469
- Although Individual #557 and Individual #563 were enrolled in school, a vocational assessment was warranted because they were in the transition years of high school. Individual #557 had also expressed an interest in working as he continued with his coursework towards graduation from high school. Both school-aged individuals would benefit from working, at least part time, during their summer vacation.
- Although Individual #463 was of retirement age and a vocational assessment was not required, she clearly expressed an interest in working at her ISP meeting held the week of the onsite visit. It would be appropriate to complete an assessment of her vocational skills and interests so that her expressed desire to work can be addressed.
- Individual #369 was approaching retirement age and had a day program assessment in lieu of a vocational assessment (and therefore was scored 1 for this sub-indicator).

11. As noted in the QIDP tracking data, assessments that were completed were available by the identified due date for all nine individuals.

12. There were recommendations for SAPs in the Functional Skills Assessment for each of the nine individuals. Individual #298, Individual #239, and Individual #444 had vocational assessments, but a SAP was recommended for Individual #298 only. The day program assessments for Individual #369 and Individual #469 included a SAP recommendation. For three others (Individual #423, Individual #557, Individual #463), their alternative assessments did not include SAP recommendations. No additional assessments had been completed for Individual #563.

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.

At the time of the last review, this Domain contained 40 outcomes and 171 underlying indicators in the areas of clinical services, and implementation of plans by the various clinical disciplines. Thirty-nine of these indicators were moved to, or were already in, the category of less oversight after the last review.

Since the last review, DOJ and the State agreed that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions, and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that will be measured through Section J.12. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Abilene SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor two outcomes and 12 indicators previously in this Domain.

As a result, this Domain now contains 38 outcomes, and 159 underlying indicators. Thirty-seven of these indicators were moved to, or were already in, the category of less oversight after the last review. Presently, 11 additional indicators will move to the category of less oversight in the areas of restraint, psychiatry, behavioral health, and dental. This includes the entirety of psychiatry Outcomes #10 and #11.

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, without reliable data on psychiatric goals/indicators, progress could not be determined.

In psychiatry, the quarterly reviews contained the necessary content.

The psychiatric team should consider developing a method to more closely coordinate care with neurology for individuals who are prescribed multiple anticonvulsant medications as well as multiple psychotropic medications. Although the anticonvulsant orders did not meet the criteria for dual use, they do add to the side effect risk of the psychiatric medications.

In behavioral health, without data that are trusted and reliable, it is impossible to validly rate progress. That being said, based on the Center's reports, about half of the individuals were deemed to be making progress on problem behaviors and replacement behaviors. For less than half of the individuals who were not making progress, actions/changes were identified and suggested.

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

Center staff need to continue to improve the provision of acute medical care for issues addressed at the Center, particularly with regard to the completion of thorough medical assessments. It was positive that for the individuals reviewed who displayed signs/symptoms of acute illness that required Infirmary admission, Emergency Department (ED) visits, or hospitalizations, PCPs provided timely acute medical care, and follow-up care. Of concern, for some individuals who were hospitalized, IDTs did not hold ISPA meetings or did not document the findings of the ISPA meetings in a timely manner. Timely post-hospitalization ISPAs are important to define necessary follow-up medical and healthcare supports to reduce risks and allow for early recognition of signs and symptoms of illness, as appropriate.

For the three acute events reviewed, nurses only sometimes followed relevant guidelines with regard to the completion of necessary initial assessments. It was good to see that prior to and upon return from the ED or hospital, nursing staff assessed individuals in alignment with applicable nursing guidelines and individuals' signs and symptoms. Improvements are needed with regard to the quality of acute care plans, as well as nurses' implementation and/or documentation of the completion of the interventions.

For individuals for whom there was occasional frequent use of restraint, criteria were met for most of the indicators.

In psychiatry, when an individual was experiencing worsening symptoms, the psychiatrists revised and implemented treatment changes.

Implementation of Plans

The documentation in the behavioral and psychiatric sections of the record indicated good and effective collaboration between the two disciplines.

Performance improved on psychiatrist participation in development of the PBSP to 100%.

Throughout the onsite review week, there was evidence of BHS staff spending time in homes.

In behavioral health, there was evidence that over 80% of the staff assigned to work with the individuals had been trained on the individual's Positive Behavior Support Plan (PBSP). Further, there was evidence of ongoing training provided by behavioral health services (BHS) to staff working in the homes.

As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports due to a lack of inclusion of regular measurable 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.

Although additional work was necessary, it was positive that for a number of individuals' chronic or at-risk conditions, medical assessments, tests, and evaluations consistent with current standards of care were completed, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate. Center staff should continue to focus on making improvements in this area, which is necessary to reduce individuals' risk for harm.

Since the last review, it was good to see improvement with regard to PCPs writing orders for agreed-upon recommendations. The Center needs to focus on ensuring PCPs review consultation reports in a timely manner.

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.

With regard to dental treatment, it was positive that individuals who required topical fluoride treatments and/or restorative work received it as needed. As a result, the two related indicators will move to the category requiring less oversight.

It was good to see that adaptive equipment generally was the proper fit for individuals the Monitoring Team member observed.

Since the last review, overall, PNMP/Dining Plan implementation at Abilene SSLC showed some improvement (i.e., Round 14 – 61%, and Round 15 – 72%). Based on observations, staff completed transfers correctly. However, efforts are needed to continue to improve Dining Plan implementation, as well as positioning. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, ate at an unsafe rate, and/or were in hyperextension) 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: All but one of these indicators were scored as meeting criteria for the one individual for whom this outcome applied. Three of these indicators showed sustained high performance over this and the previous two reviews, too. Therefore, indicators 22, 23, and 25 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring, however, with sustained high performance, some of these might also be moved to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	444								
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.	0% 0/1	0/1								
21	(No longer scored)										
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	100% 1/1	1/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially	100% 1/1	1/1								

	maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	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.	N/A									
27	The crisis intervention plan was complete.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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:

18-19. Individual #444 had been restrained more than three times on each of two days in June of 2019. The IDT met within two to four days following each of these events. This had also been presented at a meeting of the Internal Peer Review Committee in late July 2019.

20. The minutes from the IDT review reflected discussion of the potential role of adaptive skills and biological/medical/psychosocial issues. There was evidence that Individual #444's medications had been adjusted. Staff had also been advised to provide greater distance when supervising Individual #444 because he reportedly did not like one to one support. It was noted, however, that the repeated restraints that occurred on 6/12/19 were in part due to Individual #444's desire to go to church with his sister. This had been an established pattern, but staff were not aware if this was continuing following an incident that occurred in April 2019. There was no evidence that staff had attempted to contact Individual #444's sister to obtain clarification regarding this matter. Lastly, although the IDT suggested that active treatment was not a contributing factor to the need for restraint, the team is advised to reassess this determination. At the time of the onsite visit, the only scheduled activity outside of his home was two and one half hours of work each week. Additionally, he was not progressing on any of the SAPs reviewed for this report. It is suggested that the team carefully assess his strengths and preferences and make an effort to increase his active engagement in work, leisure, domestic, and community skills. This young individual could live a more enriched life with appropriate teaching and supports.

22. The IDT reviewed potential environmental antecedents. During the second day of repeated restraints, the staff member was with Individual #444 in his bedroom. This was described as a small room and the staff member reportedly could not exit prior to Individual

#444 becoming aggressive. Staff have been advised to call for help and to have Ukeru pads available when working with Individual #444. Further, this last change was not found in his updated PBSP or in his CIP.

23. The IDT reviewed potential variables that were maintaining the dangerous conditions. It was determined that in both instances, restraint was necessary.

25. Although he did not have a Crisis Intervention Plan at the time of repeated restraint, one was developed and implemented in August 2019.

26. Individual #444's PBSP was reviewed in detail in the Psychology/Behavioral Health section of this report.

28. Between January and June 2019, treatment integrity was assessed at least monthly, with an average integrity of 92%. However, although it was assessed three times in the month of repeated restraint, scores were 50%, 50%, and 100%.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: For Individual #382, psychotropic medications were discontinued in 2010. An updated Reiss should have been done since then (indicator 1). Individual #406's medications were discontinued, but due to change in status/presentation, a Reiss was conducted, and showed an elevated score. She then received psychiatric evaluation and started to receive medication/supports from psychiatry. It was good to see the Reiss process working correctly for her (indicators 2 and 3). These indicators will remain in the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score										
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.											
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.											
Comments:												

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Without reliable data on psychiatric goals/indicators, progress could not be determined. That being said, when an individual was experiencing worsening symptoms, the psychiatrists revised and implemented treatment changes. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463
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.	N/A									
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 5/5	1/1	1/1		1/1		1/1		1/1	
11	Activity and/or revisions to treatment were implemented.	100% 5/5	1/1	1/1		1/1		1/1		1/1	

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

In the absence of reliable psychiatric indicator/goal data (indicator 7), it was not possible to determine if goals were being met.

9. Given no goals were identified as being met, this was not applicable.

10. Three of the individuals were stable and did not require treatment revisions. For the other five, it was clear that the psychiatric team determined that if an individual's clinical status was worsening, they would intervene with revisions to treatment.

11. The revisions to treatment were uniformly implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Performance improved on psychiatrist participation in development of the PBSP to 100%. 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	423	298	557	239	563	444	369	469	463

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.	100% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1	
Comments: 24. The psychiatrist's participation in the development of the PBSP could be found in two places. The first of these was the document entitled "Case Formulation Discussion" which provides information related to the psychiatrists' participation in the development of the behavioral plans. This documentation was present for seven of the individuals, all except Individual #298 and Individual #239. Individual #563 had only recently been admitted to the facility and this process had not yet been completed. The relevant information for Individual #298 and Individual #239 could be found in the Formulation section (FIT) of the Annual Psychiatric Treatment Plan. This section provided the necessary information and also indicated the name of the BHA who participated in the meeting.												

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 for individuals receiving medication for dual use.	Due to the Center's sustained performance, these indicators were moved to the 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: Given sustained high performance on this and two of the three previous reviews, this indicator (34) will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463	
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 complete and contained the required content.	

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: Given sustained high performance on this and the last three reviews (88%, 78%, 100%, respectively), this indicator (36) will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
	Comments: 36. The MOSES and Aims were performed and reviewed in a timely manner for all of the individuals, except for Individual #369 for whom the 7/17/18 MOSES was not reviewed by the provider until 8/26/18.										

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 four indicators will be moved to the category of requiring less oversight due to sustained high performance over this and the previous three reviews.			Individuals:								
#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463

40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A									

Comments:

40. The dosages of the psychiatric medications did not suggest that the goal of treatment was to sedate the individuals.

41. There was no indication that medications were being used for punishment or as substitute for treatment.

42. There was a treatment program in the record of each individual.

43. The facility did not use PEMA.

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.												
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 (indicator 5), it is impossible to validly rate progress. That being said, based on the Center's reports, about half of the individuals were deemed to be making progress on problem behaviors and replacement behaviors. For less than half of the individuals who were not making progress, actions/changes were identified and suggested. These actions were implemented. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463
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.	0% 0/1							0/1		
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	40% 2/5	1/1	0/1		0/1		1/1		0/1	
9	Activity and/or revisions to treatment were implemented.	100% 2/2	1/1					1/1			

Comments:

6. A review of PBSP progress notes indicated that Individual #557, Individual #239, Individual #563, and Individual #463 were improving on most or all of their targeted problem behaviors. Additionally, Individual #369 was making good progress on his replacement behavior. Individual #423, Individual #298, Individual #444, and Individual #469 were not making progress. While the Center was making gains in ensuring data timeliness and conducted regular assessment of inter-observer agreement (indicator 5), this indicator is rated zero for all nine individuals due to problems with documentation and the data not yet shown to be reliable.

7. The objective for the identified replacement behavior had been met by Individual #369, Individual #469, and Individual #463. As the objectives for targeted problem behaviors had not been met for Individual #469 and Individual #463, this indicator is scored for Individual #369 only. A new or updated goal had not been identified.

8-9. There was evidence that revisions had been made to the PBSP for two of five individuals. Individual #423's plan had been revised on multiple occasions, including implementation of a point system and Individual #444's plan had been updated at the time of his annual PBSP. Although medication changes had been made for Individual #469, there was no evidence of revisions to his PBSP. There was no evidence that Individual #298's PBSP had been revised or that Individual #239's worsening elopement had been addressed.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.												
Summary: For indicator 16, criteria were not met for one-third of the individuals. This needs to improve in order for this indicator to remain in the category of requiring less oversight after the next review. The individuals for whom criteria were not met were Individual #298, Individual #369, and Individual #463. The Monitoring Team also wants to note that monthly progress notes frequently summarized trainings that had occurred in the identified month. Additionally, BHS staff met at least weekly with home staff. These were positive steps in ensuring adequate staff training and open communication between direct support professionals and BHS staff.			Individuals:									
#	Indicator	Overall Score										
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
17	There was a PBSP summary for float staff.											
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.											
Comments:												

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.												
Summary: Similar to last review, graphs existed, but needed to be improved in order to be understandable and useful to clinicians and to the team. Data were presented in review meetings for three-quarters of the occurrences observed during the review week. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463
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.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		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	Due to the Center's sustained performance, these indicators were moved to the									

	of documentation of follow-up and/or implementation of recommendations made in peer review.	category of requiring less oversight.
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	

Comments:

20. Although graphs were provided for the eight individuals who had identified problem behaviors, none were considered useful for making data-based treatment decisions. In some cases, the vertical axis was labeled frequency when episodes were documented (Individual #423, Individual #239, Individual #563, Individual #463), there were no phase change lines to indicate vacations from school (Individual #557), or phase change lines for significant events were either documented inconsistently, incompletely, or not at all (Individual #298, Individual #239, Individual #563, Individual #469). The graphs for Individual #444 were difficult to read. As there were many changes noted, a legend might make the graphs more readable.

21. In the psychiatry clinics held during the onsite monitoring visit, behavioral health services staff presented current data for Individual #557, Individual #369, and Individual #469. While graphs were presented in the packet of information for Individual #444 at the meeting of the Internal Peer Review Committee, data for the month of August 2019 were not reviewed.

Outcome 8 – Data are collected correctly and reliably.

Summary: With some correction/attention to the data system for target behaviors as detailed in the comments below, indicator 26 criteria can likely be met for all individuals by the time of the next review. Data systems for replacement behaviors met criteria for all individuals and with sustained high performance, this indicator (27) might be moved to the category of requiring less oversight after the next review. The same applies to indicator 28 regarding establishment of measures of data collection quality assurances. The Center has, however, shown sustained high performance regarding implementation of the data collection assurance protocols. Thus, indicator 29 will be moved to the category of requiring less oversight. The Center had not yet met these goals (indicator 30). These indicators (26-28 and 30) will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 423	298	557	239	563	444	369	469	463
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	25% 2/8	0/1	1/1	1/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	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 targeted problem behaviors was determined to be adequate for Individual #298 and Individual #557.

For five of the other individuals (Individual #423, Individual #239, Individual #563, Individual #444, Individual #463), at least one of their targeted problem behaviors was measured as an episode. Episodes were separated by the passage of time (i.e., 30 seconds to 15 minutes) without the occurrence of the targeted response. As episodes can vary dramatically in length, it is likely that this measurement system results in an underreporting of the problem. Staff are advised to consider measuring the duration of episodes or converting to a partial interval recording system using relatively short intervals of time (e.g., five minutes).

For Individual #469, stealing was measured in part by counting the number of items not belonging to him during a weekly search. As items may have been placed in his room by others, this is not an adequate measure of this behavior.

Individual #369 was excluded from this analysis because he had no identified targeted problem behaviors. However, to help determine progress during psychiatric clinic, Individual #369's behavior health specialist had developed a rating scale to assess behaviors related to his diagnosis of Autism Spectrum Disorder. This scale, which focused on self-injurious and repetitive behaviors, was not validated. Further, the scale was completed through interview with one staff member from each of the two day time shifts. It would be more appropriate to measure these two behaviors, either throughout the day or by conducting time samples throughout the week to determine the observed rate of these behaviors. Subjective assessment by select staff members was not adequate.

27. For all of the nine individuals, the data collection system was adequate in documenting identified replacement behavior(s).

28. There were established acceptable measure of data collection timeliness and IOA for all nine individuals. As documented in the PBSP for eight individuals, treatment integrity was assessed via observation of staff working with the individual. The exception was Individual #239 whose plan did not clearly identify this method of assessment.

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 seven individuals, including Individual #423, Individual #298, Individual #557, Individual #563, Individual #444, Individual #369, and Individual #463. Quarterly monitoring was identified for Individual #239 and Individual #469. As both of these individuals were not making progress on at least one of their target behaviors, more frequent monitoring is warranted. Data timeliness, IOA, and treatment integrity levels were expected to be 90% for eight of the nine individuals. The exception was Individual #444 whose 2018 PBSP identified expected levels of 80% or better.

30. In no case were all goal frequencies and levels achieved. Data timeliness goals were achieved for Individual #239, IOA goals were achieved for Individual #469, and treatment integrity goals were achieved for Individual #298, Individual #444, and Individual #469. For all other individuals, either the goal frequency was not met and/or the goal level was not met.

Medical

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

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

#	Indicator	Overall Score	Individuals: 469	563	100	150	383	406	411	425	382
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.	22% 4/18	0/2	1/2	0/2	1/2	0/2	0/2	0/2	2/2	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 #469 – infections, and GI problems; Individual #563 – falls, and weight; Individual #100 – fluid imbalance, and respiratory compromise; Individual #150 – falls, and weight; Individual #383 – cardiac disease, and fractures; Individual #406 – GI problems, and UTIs; Individual #411 – GI problems, and falls; Individual #425 – diabetes, and UTIs; and Individual #382 – GI problems, and other: pica).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #563 – weight; Individual #150 – weight; and Individual #425 – diabetes, and UTIs.

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

Outcome 4 – Individuals receive preventative care.											
Summary: Seven of the nine individuals reviewed received the preventative care they needed. 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. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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	N/A	N/A	1/1	1/1	1/1	N/A	N/A
	iii. Breast cancer screening	100% 2/2	N/A	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	86% 6/7	1/1	N/A	1/1	N/A	1/1	1/1	0/1	1/1	1/1
	vii. Cervical cancer screening	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. Overall, the individuals reviewed generally received timely preventive care, which was good to see. The following problems were noted: • On 4/18/18, Individual #100 had an audiological evaluation, which recommended a repeat evaluation in a year. Follow-up was not found in the submitted documents. • Individual #411's last DEXA scan, on 9/25/15, resulted in a T-score of -4.1. No repeat DEXA scan was found in the submitted											

documents.

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. In other words, the PCP should review the QDRR, provide an interpretation of the results, 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 with reference, as appropriate, to documents/meetings with psychiatry, etc.

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	469	563	100	150	383	406	411	425	382
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.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. On 7/9/19, the IDT for Individual #100 held an ISPA meeting and discussed the need for hospice. In 2016, he had a tracheostomy placed. His respiratory status has been challenged by frequent aspiration pneumonia (i.e., 19 events in the year leading up to June 2019, and nine hospitalizations since January 2018 for aspiration pneumonia/pneumonia), with additional challenges of emesis with aspiration from other medical problems (e.g., seizures, gastritis, anomalous stomach anatomy). Medical and surgical interventions had been maximized. He had chronic respiratory failure and might have become ventilator dependent, as his hospitalizations had become more frequent in the past year. Initially, his family did not want him transitioned to hospice care, but on 8/3/19, the family agreed.

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

Summary: Center staff need to continue to improve the provision of acute medical care for issues addressed at the Center, particularly with regard to the completion of thorough medical assessments. It was positive that for the individuals reviewed who displayed signs/symptoms of acute illness that required Infirmary admission, ED visits, or hospitalizations, PCPs provided timely acute medical care, and follow-up care. Of concern, for some individuals who were hospitalized, IDTs did not hold ISPA meetings or did not document the findings of the ISPA meetings in a timely manner. Timely post-hospitalization ISPAs are important to define necessary follow-up medical and healthcare supports to reduce risks and allow for early recognition of signs and symptoms of illness, as appropriate. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall	469	563	100	150	383	406	411	425	382

		Score									
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.	59% 10/17	2/2	1/2	2/2	1/2	1/1	2/2	0/2	1/2	0/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	80% 8/10	2/2	N/A	1/2	1/1	1/1	0/1	1/1	2/2	N/A
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.	100% 9/9	2/2	N/A	2/2	N/A	1/1	1/1	2/2	1/1	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 4/4	2/2		N/A		1/1	N/A	N/A	1/1	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance, these indicators 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.										
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	50% 3/6	1/2		1/2		N/A	1/1	0/1	N/A	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 8/8	2/2		2/2		N/A	1/1	2/2	1/1	

Comments: a. For the nine individuals reviewed, the Monitoring Team reviewed 17 acute illnesses addressed at the Center, including: Individual #469 (stomach pain on 5/9/19, and swollen left foot on 6/13/19), Individual #563 (bug bites on 6/10/19, and head banging on 6/4/19), Individual #100 (dermatitis on 2/20/19, and hypoxia on 2/21/19), Individual #150 (pica on 2/28/19, and headache on 3/20/19), Individual #383 (ankle fracture on 5/3/19), Individual #406 (bruise on finger on 5/7/19, and substomal hernia on 5/21/19), Individual #411 (bump to forehead on 4/25/19, and fall on 5/17/19), Individual #425 (UTI on 4/21/19, and cellulitis to left elbow on 1/24/19), and Individual #382 (pica on 2/24/19, and hit head on lift on 4/10/19).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #469 (stomach pain on 5/9/19, and swollen left foot on 6/13/19), Individual #563 (bug bites on 6/10/19), Individual #100 (dermatitis on 2/20/19, and hypoxia on 2/21/19), Individual #150 (headache on 3/20/19), Individual #383 (ankle fracture on 5/3/19), Individual #406 (bruise on finger on 5/7/19, and substomal hernia on 5/21/19), and Individual #425 (cellulitis to left elbow on 1/24/19).

b. PCP often conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized. The exceptions were for: Individual #100 (dermatitis on 2/20/19), and Individual #406 (substomal hernia on 5/21/19).

The following provide examples of concerns noted:

- According to a nursing IPN, dated 6/4/19, at 5:50 p.m., Individual #563 engaged in head banging. Although the on-call PCP wrote an IPN, dated 6/4/19, at 6:14 p.m., which documented a phone call with the nurse, the on-call PCP did not provide a definitive or differential diagnosis in the note. The PCP ordered nursing staff to complete one neurological check.
- On 2/20/19, for Individual #100's dermatitis, the PCP wrote an order for Lotrimin, and indicated follow-up would occur in two weeks. Based on submitted documents, the PCP did not conduct follow-up.
- According to a nursing IPN, dated 2/28/19, at 10:53 a.m., and a PCP IPN, dated 2/28/19, at 11:21 a.m., Individual #150 swallowed a piece of plastic cup or a trinket. The PCP did not conduct a physical exam of the individual and did not provide a definitive or differential diagnosis. The PCP ordered a chest x-ray and KUB (abdominal x-ray). Later, on 2/28/19, at 1:53 p.m., the PCP wrote an IPN and reported that the KUB suggested constipation. The PCP ordered a bisacodyl suppository.
- According to an IPN, dated 5/21/19, at 3:06 p.m., the PCP assessed Individual #406's substomal hernia, which was the result of past surgery. However, the PCP did not write a follow-up order for a surgical consultation.
- On 4/25/19, Individual #411 bumped his head while leaning forward in his wheelchair. Based on review of a PCP IPN, dated 4/25/19, at 9:40 p.m., the PCP did not provide a definitive or differential diagnosis.
- On 5/17/19, Individual #411 fell. According to the on-call note, the provider ordered mild neurological checks without providing a definitive or differential diagnosis. The nurse was to move the individual's wheelchair into the bedroom, and review the new bed. The PCP ordered a urinalysis. On 5/18/19, the individual fell again. The PCP ordered neurological checks for 24 hours, and Tylenol. Habilitation Therapy was to conduct an assessment. The individual's level of supervision was to be discussed with the Administrator on Duty.
- According to a PCP IPN, dated 4/21/19, at 5:35 p.m., the on-call provider ordered a complete blood count (CBC), comprehensive metabolic panel (CMP), urinalysis, and Tylenol for Individual #425, based on nursing staff's report of symptoms. However, the PCP did not document a definitive or differential diagnosis. Based on the results of the lab work, at 8:45 p.m., the individual was diagnosed with a UTI. The PCP ordered Rocephin. The PCP completed follow-up on 4/22/19, and 4/24/19.
- On 2/24/19, nursing staff reported that Individual #382 ate two inches of a brief. The on-call provider wrote a note, but did not provide a definitive or differential diagnosis. The PCP ordered that nursing staff implement the pica guideline.
- On 4/10/19, Individual #382 hit her head on the lift. According to the PCP IPN, dated 4/10/19, at 6:46 p.m., the on-call provider did not provide a definitive or differential diagnosis. The on-call provider ordered mild neurological checks with follow-up as needed.

c. For six of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses/occurrences that required Infirmary admission, hospitalization, or an ED visit, including those for Individual #469 (hospitalization for possible sepsis on 5/3/19, and hospitalization for possible sepsis on 6/5/19), Individual #100 (hospitalization for respiratory distress on 5/25/19, and hospitalization for dehydration and altered mental status on 6/15/19), Individual #383 (Infirmary admission for seizure/emesis on 4/12/19), Individual #406 (hospitalization for GI bleed on 5/21/19), Individual #411 (ED visit for pain in right hip, and hospitalization for coffee ground emesis on 5/8/19), and Individual #425 (ED visit for urinary retention on 3/6/19).

c., d., g., and h. It was positive that for the individuals reviewed who displayed signs/symptoms of acute illness that required Infirmary admission, ED visits or hospitalizations, PCPs provided timely acute medical care, and follow-up care.

For three hospitalizations, IDTs did not hold and/or document ISPA meetings to develop follow-up medical and healthcare supports to reduce individuals' risks to the extent possible.

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

Summary: Since the last review, it was good to see improvement with regard to PCPs writing orders for agreed-upon recommendations. The Center needs to focus on ensuring PCPs review consultation reports in a timely manner. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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.	69% 9/13	2/2	N/A	2/2	N/A	2/2	0/2	1/1	1/2	1/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	92% 12/13	2/2		2/2		1/2	2/2	1/1	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1	N/A		1/1		N/A	N/A	N/A	N/A	N/A

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 13 consultations. The consultations reviewed included those for Individual #469 for urology on 6/24/19, and ophthalmology on 6/24/19; Individual #100 for hematology on 6/25/19, and urology on 6/27/19; Individual #383 for orthopedics on 6/18/19, and neurology on 6/14/19; Individual #406 for

urology on 6/27/19, and podiatry on 5/21/19; Individual #411 for ophthalmology on 1/30/19; Individual #425 for urology on 4/5/19, and ophthalmology on 4/2/19; and Individual #382 for gastroenterology (GI) on 7/1/19, and neurology on 1/4/19.

b. PCPs did not complete the following reviews timely: Individual #406 for urology on 6/27/19, and podiatry on 5/21/19; Individual #425 for urology on 4/5/19; and Individual #382 for neurology on 1/4/19.

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 exception of the following: Individual #383 for neurology on 6/14/19 (i.e., Zonogram level).

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

Summary: Although additional work was necessary, it was positive that for a number of individuals' chronic or at-risk conditions, medical assessments, tests, and evaluations consistent with current standards of care were completed, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate. Center staff should continue to focus on making improvements in this area, which is necessary to reduce individuals' risk for harm. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 469	563	100	150	383	406	411	425	382
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.	67% 12/18	2/2	1/2	2/2	1/2	2/2	2/2	1/2	1/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #469 – infections, and GI problems; Individual #563 – falls, and weight; Individual #100 – fluid imbalance, and respiratory compromise; Individual #150 – falls, and weight; Individual #383 – cardiac disease, and fractures; Individual #406 – GI problems, and UTIs; Individual #411 – GI problems, and falls; Individual #425 – diabetes, and UTIs; and Individual #382 – GI problems, and other: pica).

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 #469 – infections, and GI problems; Individual #563 – falls; Individual #100 – fluid imbalance, and respiratory compromise; Individual #150 – falls; Individual #383 – cardiac disease, and fractures; Individual #406 – GI problems, and UTIs; Individual #411 – GI problems; and Individual #425 – UTIs. The following provide examples of concerns noted:

- Individual #563's IDT rated her at high risk for weight. She was clinically obese. Different documentation provided different body mass index (BMI) calculations without explanation. For example, her admission AMA stated her BMI was 40.1, but the nutritional assessment documented her BMI as 32.7. At the time of her admission, on 5/21/19, her weight of 179 pounds exceeded the recommended weight range of 108 to 136 pounds. In addition, she had risk factors, including a family history of diabetes mellitus, and she was prescribed an atypical antipsychotic. Prior to her admission, she received a regular diet. A lipid

panel, dated 5/23/19, indicated her triglycerides were 374, her high-density lipoprotein (HDL) was 29, and her low-density lipoprotein (LDL) was 141. The PCP prescribed Pravastatin for the dyslipidemia. Her blood glucose was 95. Her abdominal circumference was 43.5 inches. According to the Quarterly Drug Regimen Review (QDRR), dated 5/28/19, she met the criteria for metabolic syndrome. Upon her admission, she was placed on a weight maintenance diet with no restriction on concentrated sweets. On 6/3/19, the PCP consulted nutrition services due to the dyslipidemia and the individual's risk of diabetes. On 6/17/19, the nutritionist recommended a low cholesterol, no concentrated sweets weight maintenance diet of 2000 calories per day. Her prior regular diet provided 2240 calories per day.

The discrepancy in the initial BMI calculations needed resolution. In addition, this individual has a significant challenge due to her overweight status, but remained on a weight maintenance diet. Without further explanation in the nutritional assessment, it was unclear how this diet was expected to have a positive impact on weight reduction. She remained highly mobile and energetic. It would be helpful to formalize an exercise program, including, while taking into consideration her preferences, definitions of the types of exercise in which she should engage, with frequency, and length of time of sessions, as well as a plan for monitoring the time she participates in each session. She appeared to enjoy dancing and spinning, but the IDT had not incorporated these activities into a formal exercise program.

- Individual #150's AMA recorded her BMI as 28.34, placing her in the overweight category, and in the 12 months prior to 2/8/19, she gained 6.6 pounds. She had a diagnosis of hypothyroidism, but did not have metabolic syndrome, diabetes, or hyperlipidemia. She did not smoke. She was prescribed a 1200-calorie diet. She received additional daily calories in the form of preferred snack items and reinforcers, so that her daily intake was over 2200 calories per day. She had occasional meal refusals (i.e., 27 meal refusals in the prior six months). Reportedly, her meal intake was 75 to 100%. She remained active and was ambulatory. She was on thyroid replacement, with thyroid testing completed annually. On 1/28/19, her lipid panel was normal. According to her AMA, dated 3/11/19, she was prescribed an atypical antipsychotic, placing her at risk for increased weight gain and metabolic syndrome. She was 14% over her recommended weight range. Despite her documented weight gain, there was no indication that the IDT planned to implement a specific weight reduction plan (e.g., formal exercise program, such as stationary bike riding for 30 minutes five times per week, reduction in snacks, using non-food reinforcers, etc.). Given that she continued to gain weight on her current diet, which placed her at increased risk for metabolic syndrome in the future, additional steps were needed to change this pattern.

- Historically, Individual #411 had a history of fractures and a diagnosis of osteoporosis. In 2006, he had a compression fracture of the second lumbar vertebra. On 10/22/12, he had a nondisplaced hairline fracture through his left hemipelvis. A DEXA scan, dated 9/25/15, indicated a T-score of -4.1. According to his IRRF, dated 12/21/18, on 11/13/17, the IDT reportedly agreed to no longer pursue DEXA scans due to his age and a history of worsening behaviors with sedation. The AMA did not reflect this information and the plan of care indicated a DEXA scan was due in September 2017, with plans to "check status of updated DEXA scan." It appeared the PCP was not aware of the IDT's previous decision. Moreover, it was not clear how his worsening osteoporosis was to be followed, and/or how the effectiveness of the denosumab and calcium and/or vitamin D supplements in improving his bone density was to be measured. In addition, during the six months prior to the Monitoring Team's review, he fell at least eight times. The PCP needed to work with the IDT to determine next steps with regard to further evaluation of his osteoporosis.

- Individual #425 had metabolic syndrome. On 1/2/11, he was diagnosed with dyslipidemia (with low HDL and high triglycerides). More recently, on 3/12/19, he was diagnosed with diabetes mellitus. He was prescribed an atypical antipsychotic, which increases the risk of weight gain. Of note, he was not obese, and he did not have hypertension, and did not smoke.

  On 3/12/19, his hemoglobin (Hgb) A1C was 6.5, his triglycerides were 443. An ISPA, dated 3/22/19, indicated a change of status for the category of diabetes mellitus. The IDT agreed to provide sugar-free sodas. An ISPA, dated 4/8/19, indicated his diet was restricted to meet the challenge of controlling his diabetes mellitus. It was changed to a 2000-calorie-controlled diabetic diet with limited sugars and reduced lactose. On 6/11/19, his Hgb A1C was 5.9, total cholesterol was 171, HDL was 27, and triglycerides were 335.

  Current medications included Simvastatin, omega 3 fish oil, niacin, and metformin. Monitoring included an annual lipid panel, monthly blood pressure recordings, monthly weight, Hgb A1C and fasting blood glucose every three months, urine microalbumin to creatinine ratio annually, an annual diabetic eye exam (most recent exam on 4/2/19), and periodic podiatry exams (most recent on 7/1/19).

  The continued use of niacin 1000 milligrams (mg) ER daily needed further review, and the AMA needed to document its benefit. He already was taking a statin, and the benefit/risk ratio for continued use of niacin was not further discussed. The potential side effect of liver toxicity was ruled out, but there also are associations with hypotension and falls, increased glucose intolerance, insulin resistance, diabetes mellitus, and impaired vision. Given his recent onset of diabetes mellitus, impaired vision, and frequent falling, the use of niacin needed review and updated justification.

- Individual #382 had a diagnosis of gastroesophageal reflux disease (GERD), as well as dysphagia. On 2/26/13, and 8/19/13, she had aspiration pneumonia, as well as a health care associated pneumonia, on 4/16/15. In April 2016, there was consideration of placement of a jejunostomy tube (J-tube), but because she had no further significant aspiration reported, this option was not pursued. A 5/18/16 MBSS documented mild oral and mild pharyngeal dysphagia. She was prescribed a pureed texture diet with nectar-thick liquids. Staff fed her. According to a pulmonology consult, dated 11/22/16, she had residual scarring on her chest x-ray from a previous infiltrate or intermittent inflammatory disorder. There was consideration that this might represent the effects of silent aspiration. At the time, she had a history of wheezing with bronchospasm. On 6/16/18, she was hospitalized for respiratory distress, wheezing, pneumonia, and sepsis. On 7/17/18, a follow-up chest x-ray showed persistent infiltrates in the left lower lung and right perihilar area consistent with pneumonia. On 2/8/19, an evaluation documented she had slow movement of food in her mouth, and a delayed swallow. On 7/18/19, she had cough and rhinorrhea, and on 7/22/19, she had a cough and congestion. Current treatment included Omeprazole daily, budesonide nebulizer treatments twice daily, and an albuterol inhaler, as needed. Her PNMP provided instruction in treating her GERD, including during medication administration, oral care, reflux precautions, and positioning, and she was on an anti-reflux high-calorie diet.

  Since May 2016, she had not had a repeat MBSS, and a subsequent pulmonary consult identified concerns with silent aspiration, with chest x-ray reports and signs and symptoms suggesting aspiration (e.g., cough, and wheezing). Based on review of

documentation submitted, additional vigilance was needed to ensure she was not silently aspirating. The gastroenterologist followed her for hepatitis C, but there was no ongoing evaluation for potential worsening GERD, or to determine whether a gastric motility disorder was occurring.

- On 2/24/19, a direct support professional reported that Individual #382 ripped a piece of blue plastic brief and it was in her mouth. The staff member was unable to remove it. The nurse notified the PCP, and initiated a pica guideline for monitoring, which included vital signs every four hours for 72 hours. On 4/3/19, the sewing room was asked to make her a pica pillow for her positioning. A note, dated 7/2/19, indicated she used a pica blanket on an ongoing basis. A behavioral staff instruction sheet, dated 7/19/18, indicated that she had a history of chewing on socks, wash cloths, etc., and that this activity would increase her salivation and risk of choking. If staff found her chewing on anything other than her pica blanket, staff were to ask her to give the items to staff, and if she refused, to gently remove the items. Staff were to make sure that she had access to her pica blanket throughout the day. In the AMA, dated 5/21/19, the PCP did not address pica. The IRRF reviewed prior behavioral health action steps, but pica prevention was not mentioned. There was no information on how staff were to prevent her from ripping off another piece of plastic from her brief. The submitted PNMP did not mention the possible use of cloth adult briefs instead of plastic. It was unknown if staff completed monitoring to ensure her pica blanket was available to her throughout the day, nor was it clear that all staff had been trained on the 7/19/18 behavior instruction sheet, or if necessary, refresher training had occurred. Moreover, based on submitted documents, the IDT had not held an ISPA meeting to discuss this most recent pica event, and/or the steps needed to prevent her pica.

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

Summary: For the nine individuals, the IHCPs reviewed included no interventions assigned to PCPs. Given their needs, this was quite problematic. 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: 469	563	100	150	383	406	411	425	382
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. For the nine individuals, the IHCPs reviewed included no interventions assigned to PCPs. Given their needs, this was quite problematic.

Pharmacy

Since the last review, based on the Center's scores over the past three monitoring cycles, DOJ and the State agreed that the Center achieved substantial compliance with most of the requirements of Section N of the Settlement Agreement. The exceptions are Section N.6 related to adverse drug reactions (i.e., see below), and Section N.8 related to medication variances that the Monitoring Team will review as part of Section E, and Section N.5 related to quarterly monitoring for tardive dyskinesia that will be measured through Section J.12. With the understanding that these topics are covered elsewhere in the Settlement Agreement, Abilene SSLC exited from the other requirements of Section N of the Settlement Agreement. Therefore, for this report, the Monitoring Team did not monitor the outcomes and indicators related to the exited provisions of the Settlement Agreement.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	1/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1
Comments: a. and b. Individual #411 was edentulous and his IDT rated him at low dental risk. The remaining eight individuals reviewed all had medium or high dental risk ratings, but none had clinically relevant, achievable and measurable goals/objectives related to dental care. The Monitoring Team has worked with State Office on this issue so that staff there could provide more guidance to the Centers about											

the development of clinically relevant goals. A good way to think about it, though, is: "what would the dentist tell the individual he/she or staff should work on between now and the next visit?" The causes of individuals' dental problems are different, and so the solution or goal should be tailored to the problem. As an example, for five individuals reviewed for this monitoring period who required goals (i.e., Individual #469, Individual #563, Individual #383, Individual #406, and Individual #425), the respective IDTs developed goals for improvement in their oral hygiene ratings. This did not address the specific reasons for the individuals' existing oral hygiene rating, and IDTs did not identify the etiology or cause of the problem. So, asking why they had issues with oral hygiene, and developing a goal/objective to address the specific "why" might have been a place to start (e.g., need for skill acquisition, increase in tolerance for staff brushing their teeth, need to floss teeth, need to follow a routine, etc.). These are the types of questions IDTs should be asking themselves when deciding upon a goal.

With regard to measurability, often goals/objectives did not provide the number of expected trials, and/or the criteria for achievement. For example, a goal that stated "complete tooth brushing 75% of the time" needed to provide the expected number of trials (e.g., 75% of trials twice each day), and did not provide criteria for achievement (e.g., for three consecutive months). For many individuals, "tooth brushing" also would need to be further defined, based on the individual's current ability to brush his/her teeth thoroughly.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable and measurable, integrated progress reports on existing goals with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews of the processes related to the provision of dental supports and services for all nine individuals, including Individual #411 who was edentulous and had low dental risk, but was part of the core group.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not Rated (N/R)									

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

Outcome 5 – Individuals receive necessary dental treatment.	
Summary: Overall, the Center made good progress with regard to the provision of necessary dental treatment. Due to the Center's sustained performance in providing needed topical fluoride applications (i.e., Round 13 - 100%, Round 14 -	Individuals:

100%, and Round 15 - 100%), and restorative work (i.e., Round 9 – 100%, Round 10 – N/A, Round 11 - 100%, Rounds 12 to 14 – N/A, and Round 15 - 100%), Indicators d and e will move to the category requiring less oversight. Indicator f will continue in active oversight.											
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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 with these indicators, they have moved to the category of 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% 3/3	1/1	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.	100% 3/3	N/A	N/A	N/A	1/1	N/A	1/1	N/A	1/1	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									
Comments: d. and e. It was positive that individuals who required topical fluoride treatments and/or restorative work received it as needed.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	If the dental emergency requires dental treatment, the treatment is provided.										
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.										

Comments: a. through c. N/A

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	67% 2/3	N/A	N/A	0/1	N/A	N/A	1/1	N/A	N/A	1/1
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: a. For two of three applicable individuals, the respective IDTs included specific and measurable suction tooth brushing strategies/plans in their ISPs/IHCPs. For Individual #100, the ISP included twice-daily suction tooth brushing, but did not indicate the duration as recommended in the annual dental summary.

b. Based on documentation submitted for each of the individuals (i.e., "Suction Toothbrushing Detailed Entry Report," dated 4/26/19-7/26/19), lapses occurred in the provision of suction tooth brushing. Reasons were not provided for the days/times that staff did not provide individuals with the required tooth brushing support.

c. Although it appeared that Center staff provided some monitoring in the homes with regard to staff's implementation of suction tooth brushing for quality, as well as safety, ISP action plans did not define the frequency expected 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. QIDP reports did not include specific data with regard to suction 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		563	100	150	383	406	411	425	382
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 with this indicator, it has moved to the category of requiring less oversight.									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: b. 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: For the three acute events reviewed, nurses only sometimes followed relevant guidelines with regard to the completion of necessary initial assessments. It was good to see that prior to and upon return from the ED or hospital, nursing staff assessed individuals in alignment with applicable nursing guidelines and individuals' signs and symptoms. Improvements are needed with regard to the quality of acute care plans, as well as nurses' implementation or documentation of the completion of the interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	50% 1/2	N/R	N/R	N/A	N/R	0/1	N/R	N/R	1/1	N/R
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.	33% 1/3			0/1		0/1			1/1	

c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/1			N/A		0/1			N/A	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	100% 2/2			1/1		N/A			1/1	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/3			0/1		0/1			0/1	
f.	The individual's acute care plan is implemented.	0% 0/3			0/1		0/1			0/1	

Comments: Given that State Office recently provided training and Center staff are at the beginning stages of developing and implementing acute care plans that reflect the training, the Monitoring Team reviewed a small number of acute care plans. Specifically, the Monitoring Team reviewed three acute illnesses and/or acute occurrences for three individuals, including those for Individual #100 for respiratory failure on 7/10/19, Individual #383 for a fracture, and Individual #425 – for urinary retention on 3/6/19.

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

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

- On 7/10/19, Individual #100 returned from a hospitalization during which he was diagnosed with aspiration pneumonia. Upon his return, the nurse conducted an assessment, but consistent with what Center staff identified with their review of this acute event, the nurse did not document notifying the PCP of findings related to coarse lung sounds or hypoactive bowel sounds. Nursing staff developed an acute care plan. It included some relevant and measurable interventions, such as the completion of vital signs twice a shift. However, other interventions were not measurable (e.g., ensure adequate hydration, encourage deep breathing) and/or did not include parameters with regard to when nursing staff should notify the PCP. Due to problems with the measurability of some of the interventions, it was not possible to determine if nurses implemented them.
- On 5/3/19, Individual #383 fractured her right lateral malleolus. In completing the initial nursing assessment, the nurse did not follow applicable nursing guidelines, nor did the nurse follow the guidelines for contacting the PCP. More specifically, at 11:55 a.m., the medication nurse noted swelling during medication pass. It was not until 3:45 p.m., that the RN documented an assessment and called the PCP. In addition, the RN's notes did not include Situation, Background, Assessment, and Recommendations (SBAR) as required by applicable guidelines.

  The PCP ordered an air splint with capillary refill checks and removal of the splint every shift. On 5/3/19, at 4:50 p.m., the splint was applied. There was no mention of removal of the splint, and the first note that identified that a nurse completed/documented checking the capillary refill was dated 5/4/19, at 8:30 a.m. At 10:30 a.m., a nurse documented another check, but then the next one did not occur until 5/5/19, at 7:30 a.m.

In conducting ongoing assessments, nurses did not consistently assess pedal pulses when they noted swelling; this was essential given that the individual had a cast. A number of problems were noted with regard to the acute care plan. For example, the problem was identified as a "risk for pain," and the acute care plan did not specifically address the fracture; it did not include interventions to assess swelling, or monitor the use of the air cast; and although the PCP ordered an air cast, the orthopedist recommended a boot, but the acute care plan did not clarify which was in use. On 5/10/19, nursing staff discontinued this acute care plan, and initiated a new one for skin integrity. If the air cast or boot were causing irritation, a plan to address skin integrity might have been appropriate, but it was unclear how nursing staff were to address the fracture and the related issues until resolution.

- On 3/6/19, at 11:12 a.m., Individual #425 experienced urethral bleeding. The nurse conducted an assessment consistent with applicable standards of care, and notified the PCP in accordance with the applicable guidelines. At 12:09 p.m., the PCP saw him, and at 1:48 p.m., he went to the ED. At 3:00 a.m., he returned from the ED, and was admitted to the Infirmary. Infirmary nursing staff conducted an assessment upon his return that followed applicable guidelines and was consistent with the individual's signs and symptoms. Although the acute care plan included a number of interventions that were consistent with applicable nursing guidelines, they were not consistently measurable (e.g., encourage fluid intake, monitor strict intake and output). It was positive to see that nurses completed some ongoing regular assessments of the individual's status. However, due to problems with the measurability of some of the interventions, it was not possible to determine if nurses implemented them.

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

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

Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant goals/objectives related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to	18%	0/2	1/2	0/1	1/2	0/2	0/2	0/2	1/2	0/2

	measure the efficacy of interventions.	3/17									
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/17	0/2	0/2	0/1	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% 0/17	0/2	0/2	0/1	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 #469 – choking, and falls; Individual #563 – cardiac disease, and weight; Individual #100 – dental, and seizures; Individual #150 – weight, and skin integrity; Individual #383 – respiratory compromise, and seizures; Individual #406 – respiratory compromise, and seizures; Individual #411 – GI problems, and cardiac disease; Individual #425 – diabetes, and infections; and Individual #382 – choking, and GI problems).

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 #563 – weight, Individual #150 – weight, and Individual #425 – diabetes.

Some medical conditions do require action plans, but do not require a goal/objective in which the individual or direct support professionals needs to engage to improve the individual's health. This included Individual #100's risk related to – seizures.

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 measurable interventions in IHCPs to address individuals' at-risk conditions, and the lack of measurable interventions made it difficult to determine if nurses implemented them. In addition, 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	469	563	100	150	383	406	411	425	382
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	11% 2/18	0/2	1/2	0/2	1/2	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% 0/3	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed a total of 18 specific risk areas for nine individuals, and the IHCPs to address them (i.e., Individual #469 – choking, and falls; Individual #563 – cardiac disease, and weight; Individual #100 – dental, and seizures; Individual #150 – weight, and skin integrity; Individual #383 – respiratory compromise, and seizures; Individual #406 – respiratory compromise, and seizures; Individual #411 – GI problems, and cardiac disease; Individual #425 – diabetes, and infections; and Individual #382 – choking, and GI problems).

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 (i.e., the exceptions were weight for Individual #563, and skin integrity for Individual #150), or that nursing interventions were implemented thoroughly. A significant problem was the lack of measurability of the supports. For example, a number of individuals' IHCPs called for nursing physical assessments, but the IHCPs did not define the frequency (e.g., every shift, every day, each Friday, on the first day of the month, etc.). As a result, it was not possible for the Monitoring Team to define whether or not nursing staff implemented the interventions/assessments.

In its comments on the draft report, the State disputed the statement about the lack of measurability, and indicated that: "Within an individual's IHCP, assessment frequency is specifically noted at the beginning of each intervention with the abbreviations of (M) Monthly, (Q) Quarterly, (W) Weekly, (A) Annually. See TX-AB-1908-II.03. a, p. 4 as an example; 'Intervention: N (M) Review any physical or chemical restraints required." To clarify, in conducting the review, the Monitoring Team member figured out what the initials meant. As discussed recently with State Office staff, the use of unapproved abbreviations is problematic, particularly in Centers that rely on agency nurses. That being said, the Monitoring Team understands that due to the limitations with IRIS, nurses often use abbreviations in an attempt to overcome issues such as character limitations. To explain the issues with measurability further, because interventions did not specify specific days of the week or month, shifts, etc., it was difficult, if not impossible, to identify in IView entries and IPNs whether or not and where nurses had documented the findings from the interventions/assessments included in the IHCPs reviewed. As discussed above, interventions did not consistently describe the parameters for assessments, and often, it appeared that when nurses completed assessments, the assessments did not cover the parameters included in related nursing guidelines/standards of care. Again, this appeared, at least to a certain degree, to be a function of issues with IRIS.

In addition, in its comments on the draft report, the State disputed the finding related to Indicator a, and stated: "The IHCP for individual [XX] is noted to have a 'Reason:' prompt under each intervention documenting implementation prior to the 14 day requirement." Based on review of the IHCPs submitted, it appears that the State referred to a note in each section of the IHCPs that identified an "Implementation Date." Such statements are not evidence of actual implementation. As indicated in the audit tool, the type of data/evidence that is needed includes IPNs, DSP Instruction Sheets, and flow sheets, etc.

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

- On 4/14/19, Individual #411 was hospitalized for a GI bleed, and on 4/18/19, he was diagnosed with small bowel obstruction. Based on review of ISPA documentation, the IDT did not meet to discuss this hospitalization (i.e., an ISPA, dated 4/25/19, documented discussion of the "pneumonia report," and mentioned the reasons for the recent hospitalization). As discussed elsewhere in this report, his IHCP for GI issues did not meet his needs. Based on the ISPA documentation submitted, the IDT did not review data related to the implementation of the IHCP, or discuss changes that were needed. On 5/16/19, well beyond the five-day requirement, the IDT discussed a change to the individuals GI risk rating, and some changes to medications. The IDT also added an intervention for "weekly abdominal girths," but did not define parameters for, for example, physician notification, based on specific measurements. The IDT also recommended an assessment to identify preferred items to encourage him to take his constipation medication, but did not set a timeframe for its completion.
- On 3/7/19, Individual #425 was diagnosed with UTI hematuria, and urinary retention for which he was admitted to the Infirmary. On 3/16/19, he went to the ED due to urinary retention. On 4/5/19, the IDT held an ISPA meeting, and decided to change his goal from: "[Individual #425] will have optimal urinary health R/T [related to] catheterization AEB [as evidenced by] no UTIs this ISP year" to "[Individual #425] will have optimal urinary health R/T catheterization AEB no further hospitalization this ISP year related to UTI." In other words, because the individual experienced the poor outcome of a UTI that the original IHCP was designed to prevent, the IDT changed the goal. During this meeting, the IDT did not review and/or document review of the action steps in the IHCP to determine whether or not staff had implemented them, and/or if they required modification. The IDT agreed to implement some recommendations, including some medical interventions (e.g., urology consult, Tylenol for pain, and lab work). The IDT also documented that nursing staff were instructed to "continue to monitor I&Os [intake and output], any increases in hematuria, and to watch for any signs and symptoms of infection, or increased pain and to notify PCP." This did not represent measurable nursing interventions.

  According to a PCP IPN, dated 4/21/19, at 5:35 p.m., the on-call provider ordered a CBC, CMP, urinalysis, and Tylenol for Individual #425, based on nursing staff's report of symptoms. On 4/21/19, he was again diagnosed with a UTI. Based on review of ISPA documentation, the IDT did not meet to discuss this additional infection and/or to make improvements to the IHCP.
- According to IPNs, on 2/24/19, a direct support professional reported that Individual #382 ripped a two-inch piece of blue plastic brief and it was in her mouth. The staff member was unable to remove it. This placed her at increased risk for choking. The nurse notified the PCP, and initiated the pica guideline for monitoring, which included vital signs every four hours for 72 hours. Based on a review of her IHCP, interventions were not in place to address pica behavior. Although the IRRF, dated 6/6/19, indicated that she used her "pica blanket," the IDT did not discuss pica, but agreed to discontinue the PBSP. There was no discussion of this recent pica incident, or any information on how staff were to prevent her from ripping off another piece of plastic from her brief.

Outcome 7 – Individuals receive medications prescribed in a safe manner.	
Summary: For at least the two previous reviews, as well as this review, Center staff	Individuals:

did well with the indicator related to nurses administering medications according to the nine rights. If the Center's high level of performance with Indicator c, and the Center's ability to self-monitor this indicator continues, after the next review, it might move to the category of less oversight. It was positive that during this review, when issues arose with regard to the indicator related to nurses adhering to infection control procedures while administering medications, the Center's nurse auditor identified the same issues as the Monitoring Team member, and took steps to address them, as necessary. During medication administration, areas that require focused efforts are: 1) nurses' implementation of individuals' PNMPs; and 2) improvement of nurses' use of infection control practices. In addition, it will be important during medication administration observations, for the Center's nurse auditor to identify problems related to PNMP implementation, as well as the implementation of respiratory assessment for individuals who need them. At this time, all of these indicators will remain in active oversight.										
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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% 8/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	1/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	N/A									
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	N/A									
d.	In order to ensure nurses, administer medications safely:										

	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	50% 1/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	1/1
	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.	63% 5/8	0/1	N/A	1/2	N/A	N/A	1/2	1/1	N/A	2/2
	a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
	b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	78% 7/8	1/1	1/1	1/1	1/1		1/1	1/1	1/1	0/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	0% 0/1	N/A	N/A	N/A	N/A		N/A	N/A	N/A	0/1
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes	0% 0/1	N/A	N/A	N/A	N/A		N/A	N/A	N/A	0/1

	necessary action.										
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	50% 4/8	1/1	0/1	0/1	0/1		1/1	1/1	1/1	0/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	100% 4/4	N/A	1/1	1/1	1/1		N/A	N/A	N/A	1/1
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	100% 4/4	N/A	1/1	1/1	1/1		N/A	N/A	N/A	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #469, Individual #563, Individual #100, Individual #150, Individual #406, Individual #411, Individual #425, and Individual #382. For Individual #383, the Monitoring Team member attempted to conduct an observation, but she refused her medication.

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

d. For the individuals reviewed, the Monitoring Team identified a number of concerns related to necessary respiratory assessments.

The following provide examples of the Monitoring Team's findings:

- On 3/25/19, Individual #469 was hospitalized for possible pneumonia. His IHCP did not provide specifics with regard to the frequency for respiratory/lung sound assessments. As such, during the observation, it was unclear whether the medication nurse needed to complete a respiratory assessment. Based on review of IView entries, nursing assessments did not consistently include lung sounds.
- For Individual #100, the medication nurse completed a lung sound assessment after the observed medication pass, because the individual coughed during medication administration. Reportedly, nurses had been completing lung sound assessments before and after medication administration and enteral feedings, but on 8/6/19, the intervention was changed to daily lung sound assessments without justification. The Center's nurse auditor did not identify this issue.
- Individual #406's record included multiple orders related to lung assessments, including: 1) lung assessment before medications and feedings for six months, dated 7/15/19; 2) lung assessment once a shift during the 6 to 2 shift and the 2 to 10 shift at a time other than medication administration, dated 8/6/19; and 3) lung assessment before medications and feeding for six months. During the medication pass the Monitoring Team member observed, the nurse completed lung sound assessments. However, based on review of records, nurses had not consistently implemented the orders.

f. For the most part, medication nurses followed the individuals' PNMPs, including checking the positions of the individuals prior to medication administration. Unfortunately, when one problem did occur, the Center's nurse auditor did not identify it, and/or take corrective action. The following concerns were noted:

- Individual #382's PNMP indicated that when nurses present medications, they should press the spoon gently downward on the individual's tongue. During the observation, the medication nurse did not follow this instruction, and the Center's nurse auditor did not identify it as a problem. In addition, the Center's nurse auditor did not address the practice of mixing medications with thickened liquids.

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

- For Individual #563 and Individual #150, the medication nurses did not sanitize their hands between glove changes. The nurse also did not ask Individual #563 to sanitize her hands when taking medications.
- For Individual #100, the medication nurse did not change gloves between preparing and administering medications, and did not follow proper procedure when administering medications through the enteral tube, which potentially contaminated the syringe tip.
- For Individual #382, the nurse had to use utensils to mix liquid medication with thickener, crush medications, and mix medications in pudding, as well as use adaptive equipment. She did not always keep the utensils on her clean field.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: At times, when needed, IDTs did not refer individuals to the PNMT and/or the PNMT did not conduct a review. In addition, IDTs and/or the PNMT did not have a way to measure clinically relevant goals/objectives related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	N/A	0/2	N/A	0/1	0/1	0/1	0/1	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/9		0/2		0/1	0/1	0/1	0/1	0/1	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9		0/2		0/1	0/1	0/1	0/1	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/9		0/2		0/1	0/1	0/1	0/1	0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/9		0/2		0/1	0/1	0/1	0/1	0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	78% 7/9	2/2	N/A	2/2	0/1	1/1	1/1	0/1	1/1	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	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	0%	0/2		0/2	0/1	0/1	0/1	0/1	0/1	

	reflective of the measurable goal/objective;	0/9									
	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 #563 – falls, and choking; Individual #150 – choking; Individual #383 – choking; Individual #406 – aspiration; Individual #411 – falls; Individual #425 - aspiration; and Individual #382 – aspiration, and choking.

a.i. and a.ii. The IHCPs reviewed did not include clinically relevant, achievable, and/or measurable goals/objectives. For a number of individuals, IDTs included goals objectives for choking or aspiration that read something to the effect of: "Individual will demonstrate safe oral intake of modified diet texture…" or "Individual will eat safely related to impulsive mealtime behaviors and/or reduced chewing ability…" Although this showed some improved thinking about the potential causes of the individuals' risks related to aspiration and choking and the strategies to address them, the IDTs had not individualized the goals/objectives or provided data to support the need for a SAP or strategies in a specific area(s). For example, based on monitoring results, was the individual or staff not cutting the food to the proper diet texture, was the individual not adhering to specific dining techniques designed to slow his/her rate of eating, and/or did the individual need therapy to improve his/her chewing ability to enhance safety during eating? Depending on the findings, the IDT could then individualize the goal/objective to work on improvements in the specific prioritized area(s) in order to mitigate the risk to the extent possible. Analysis of such data should be included in the IRRF to support the goals/objectives that the IDT considered and agreed upon. The goal/objective needs to be specific and measurable, so IDTs need to replace references such as "impulsive mealtime behavior" or "reduced chewing ability" with descriptions of specific skills that individuals need to demonstrate (e.g., placing fork down between every two bites, or clearing oral cavity between bites of food). Measurable criteria for achievement also would need to be components of the goals/objectives.

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 those for: Individual #469 - aspiration, and GI problems; Individual #100 – constipation/bowel obstruction, and aspiration; Individual #150 – falls; Individual #383 – falls; Individual #406 – GI problems; Individual #411 – aspiration; and Individual #425 - falls.

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

- Based on review of IPNs, on 10/26/18, Individual #100 met criteria for referral to the PNMT due to a small bowel obstruction. The PNMT stated that they would complete a review and report findings, but they did not complete a review. Almost immediately, the individual was re-admitted to the hospital. Upon his return to the Center, on 11/15/18, the PNMT stated that oversight was no longer needed, because the aspiration was caused by the small bowel obstruction, which the PCP was addressing with increased bowel management. A PNMT review was still warranted with findings from the PCP's plan integrated. The PNMT should have, for example, conducted observations related to positioning, as well as reviewed other factors that could impact emesis, constipation, and aspiration. Of note, on 2/10/19, he was diagnosed again with a bowel

obstruction, and between 1/3/19 and 7/28/19, he experienced at least 29 episodes of emesis (i.e., according to Document #TX-AB-1908-II.P.1-20). In addition, between October 2018 and 7/6/19, he had eight respiratory-related illnesses/hospitalizations, which resulted in repeated assaults on his lungs. It was not until June 2019, that the PNMT even conducted a review (i.e., referral date 6/21/19). In addition, despite ongoing issues, it was not until 6/11/19, that results from a GI workup were noted. At that point, they identified the individual had a J-shaped stomach, which required increased elevation. When all of the issues began in October 2018, involvement of the PNMT should have resulted in discussion and trials of increased elevation.

- Individual #150 had a significant history of falls. For example, in 2016, she experienced six falls; in 2017, she fell 42 times, in 2018, she fell 79 times; and between January 2019 and August 2019, she experienced over 200 falls. It was not until 1/18/19 that the PNMT conducted a review (i.e., referral on 1/9/19).
- In response to Individual #411's diagnoses of aspiration pneumonia and small bowel obstruction, on 4/14/19, the PNMT did not conduct a review. According to PNMT minutes, dated 4/23/19, the PNMT concluded that a review was not needed, because the "root cause" of the pneumonia was the small bowel obstruction, and the PCP prescribed Docusate Senna. A PNMT review was still warranted as opposed to only a review of the medication. For example, the PNMT should have reviewed other relevant supports, such as positioning, the individual's intake of fluids, as well as his active mobility, such as walking, all of which are areas that can impact these risk areas.

As noted with regard to Outcome #2 above, n its comments on the draft report, the State disputed many of the findings above. The Monitor reviewed the State's comments in detail and made no substantive changes to the original findings. As these findings illustrate, many individuals at the Center have unmet PNM needs. The Monitoring Team encourages the Center Administration to consider steps that the PNMT needs to take to improve the supports and services it provides to identify the underlying causes of individuals' PNM needs, and work with IDTs to develop and implement supports responsive to those needs. In order to make this possible, further training for PNMT members might be needed to assist them in completing thorough analyses, identifying underlying cause(s), developing interventions to address them, setting out goals/objectives to assist in determining whether or not the interventions are effective in addressing the suspected causes, and using data to determine whether or not changes to the interventions are needed.

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

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.	
Summary: None of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Substantially more work is needed to document that individuals receive the PNM supports they require. In addition, in numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased	Individuals:

or they experienced changes of status. At this time, these indicators will remain in active oversight.											
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
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.	15% 2/13	0/2	0/1	0/2	0/1	1/2	0/1	0/2	1/2	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 4/4	1/1	N/A	N/A	1/1	N/A	1/1	N/A	1/1	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 include specific information or data about the status of the implementation of the action steps that IHCPs did include.

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

- On 6/5/19, Individual #469 was diagnosed with pneumonia, for which the etiology was unclear (e.g., bacterial, aspiration). He also had been hospitalized several times for respiratory-related illnesses and/or suspected sepsis (i.e., on 3/25/19, to rule out sepsis and possible pneumonia; on 4/14/19, for respiratory distress, abdominal distention, vomiting and hypoxia; on 5/3/19, for possible sepsis; and on 6/5/19, for fever and sepsis). Additionally, the individual was known to not follow his prescribed thickened liquid consistency, and at times, drank thin liquids (e.g., on 3/5/19), as per a QIDP monthly note, dated, 7/1/19. Based on information provided in Document #TX-AB-1908-II.P.1-20, between 3/23/19, and 7/8/19, the individual experienced 14 episodes of emesis. With all of these factors that elevated his level of risk, his IDT should have, but did not complete head-of-bed elevation (HOBE) evaluations, and/or observations of the supports in place. Even if the IDT believed they knew the cause of the emesis, they needed to conduct observation to ensure that when it did occur, the supports in place were effective in addressing it.
- According to an ISPA, dated 7/18/19, between May and June 2019, Individual #563 fell seven times. No evidence was found to show that the PT completed observations to determine if different shoes would prevent the individual's loss of balance.

  In its comments on the draft report, the State disputed this finding, and cited as evidence information from an OT/PT assessment, dated 6/19/19, which was before the ISPA meeting, on 7/18/19. Based on documentation submitted, the OT/PT did not follow-up to assess/address the IDT's recommendation related to the possibility of rubber-soled sandals to determine if they would meet the individual's needs, as well as address her preferences.
- Based on review of IPNs, on 10/26/18, Individual #100 was hospitalized with a small bowel obstruction, and aspiration pneumonia. Upon his return to the Center, he was almost immediately re-admitted to the hospital. Upon his re-return to the Center, on 11/15/18, the PCP increased bowel management medications. On 2/10/19, the individual was diagnosed again

with a bowel obstruction, and between 1/3/19 and 7/28/19, he experienced at least 29 episodes of emesis (i.e., according to Document #TX-AB-1908-II.P.1-20). In addition, between October 2018 and 7/6/19, he had eight respiratory-related illnesses/hospitalizations, which resulted in repeated assaults on his lungs. In addition to a lack of PNMT review/assessment, the IDT did not conduct positioning evaluations or HOBE evaluations. For example, Habilitation Therapy staff should have trialed alternate positioning along with review of the individual's residuals. In addition, despite ongoing issues, it was not until 6/11/19, that results from a GI workup were noted. At that point, the IDT identified the individual had a J-shaped stomach, which required increased elevation. After the Monitoring Team's onsite review, on 9/27/19, Individual #100 died with causes of death pending.

- Individual #150 had a significant history of falls. For example, in 2016, she experienced six falls; in 2017, she fell 42 times, in 2018, she fell 79 times; and between January 2019 and August 2019, she experienced over 200 falls. On 11/30/18, the PNMT referred the individual back to the IDT for a "root cause" analysis. It was not until 4/8/19, that the IDT began the "root cause analysis process, and as of 6/28/19, it was still ongoing. The individual continued to fall.
- On 1/28/19, Individual #383 had a coughing episode during mealtime. It was positive that Habilitation Therapy staff completed a dysphagia assessment that same day. However, her last Modified Barium Swallow Study (MBSS) was completed in 1993. With a noted decrease in skills, detailed swallow interventions, and the time that had passed since the previous MBSS, a repeat was warranted.
- It was positive that Individual #406's IDT consulted with Behavioral Health Services to address self-induced vomiting, and the PCP increased the prescription for Nexium. However, the IDT failed to conduct a thorough review, investigating, for example, the individual's level of activity and the impact on vomiting, overall positioning requirements, etc.
- As discussed elsewhere in this report, in response to Individual #411's diagnoses of aspiration pneumonia and small bowel obstruction, on 4/14/19, the PNMT did not conduct a review, but should have. According to a PNMT note, dated 4/23/19, this individual had a significant history of aspiration pneumonia (i.e., on 10/14/18, 12/27/18, 3/9/19, and this event on 4/14/19). In response to the diagnoses on 4/14/19, of aspiration pneumonia and small bowel obstruction, the individual's IDT did not increase its monitoring to determine whether or not staff were implementing interventions as required, and/or to determine whether or not they needed to make changes to interventions.
- On 6/26/19, in response to the guardian's concerns about Individual #425's coordination between breathing and swallowing, the OT completed a consultation. The OT concluded that the individual had a weak cough and decreased rotary chew, and indicated that another assessment would be completed with the Speech Language Pathologist (SLP). However, based on the documents submitted, the therapists did not complete the needed follow-up assessment/consultation.
- According to Document #TX-AB-1908-II.P.1-20, between February and July 2019, Individual #425 fell 39 times. It was positive that the PT conducted an assessment and initiated a formal PT program in response to the falls.

As with Outcome #1 and Outcome #2, the State disputed a number of the findings in this section. The Monitor reviewed the comments in detail, and made no changes to the original findings.

c. For the individuals reviewed whom the PNMT had discharged, their IDTs held ISPA meetings during which the PNMT shared information from its reviews.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Since the last review, overall, PNMP/Dining Plan implementation at Abilene SSLC showed some improvement (i.e., Round 14 – 61%, and, Round 15 – 72%). Based on observations, staff completed transfers correctly. However, efforts are needed to continue to improve Dining Plan implementation, as well as positioning. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, ate at an unsafe rate, and/or were in hyperextension) 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.	72% 28/39	
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.	Not rated (N/R)	

Comments: a. The Monitoring Team conducted 39 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during nine out of 11 observations (82%) . Staff followed individuals' dining plans during 17 out of 26 mealtime observations (65%). Staff completed transfers correctly during two out of two observations (100%).

The following provides more specifics about the problems noted:

- With regard to Dining Plan implementation, the great majority of the errors related to staff not using correct techniques (e.g., cues for slowing, presentation of food and drink, prompting, etc.). Individuals were at increased risk due to staff's failure, for example, to intervene when they took large unsafe bites, ate at too fast a rate, or staff did not provide liquids in between bites. In one instance, an individual began coughing, and staff encouraged the individual to drink, which increased her risk for choking and/or aspiration. In three instances, individuals were not positioned correctly, including two individuals who were in hyperextension. During the observations, it was good to see that texture/consistency was correct, and that adaptive equipment was correct.
- With regard to positioning, two individuals were not positioned correctly. For example, one individual's legs were pinned behind the footrests while a staff member was pushing him in the wheelchair.

For the two transfers observed, it was good to see that staff used proper techniques.

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	469	563	100	150	383	406	411	425	382
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			
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: While a few individuals reviewed had clinically relevant goals/objectives identified to address their needs for formal OT/PT services, the IDTs often did not integrate those goals/objectives into their ISPs. In addition, monthly integrated progress reports did not include data related to any of the 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	469	563	100	150	383	406	411	425	382
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	14% 1/7	0/2	N/A	N/A	1/1	N/A	N/A	0/1	0/2	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/7	0/2	N/A	N/A	0/1	N/A	N/A	0/1	0/2	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/7	0/2			0/1			0/1	0/2	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/7	0/2			0/1			0/1	0/2	0/1

e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/7	0/2			0/1			0/1	0/2	0/1

Comments: a. and b. Individual #563 did not require OT/PT supports. Two of the nine individuals reviewed (i.e., Individual #383 and Individual #406) did not have a clear need identified that would require OT/PT goals/objectives, but they did require OT/PT supports and services. In addition, due to Individual #100's ongoing medical status, no goal was warranted. For the remaining five individuals, the goals/objectives that were clinically relevant and achievable were those for Individual #469 (i.e., increase ambulation distance, and demonstrate fair standing balance), and Individual #425 (i.e., improved lower extremity strength, and improved eye-hand coordination). However, the IDTs did not include the individuals' specific goals in the respective ISPs/IHCPs or incorporate them through an ISPA. Although Individual #150's goal/objective (i.e., place setting at the table) was clinically relevant and the IDT included it as the independence goal in her ISP, it was not clearly measurable (i.e., did not clearly state the criteria for mastery).

c. through e. Overall, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The following provide examples of concerns noted:

- For the goals/objectives cited above for Individual #469 and Individual #425, data were submitted to show they were implemented, but no evidence was found to show the PT worked with the QIDP to analyze the data and include it in the monthly integrated progress reports for the IDTs' consideration.
- Center staff did not submit any evidence that Individual #150's goal/objective had been implemented or otherwise reviewed in the monthly integrated progress reports.

The Monitoring Team conducted full reviews for the nine individuals. This included Individual #563, who did not have a need for OT/PT services, but was part of the cross-team review group, and Individual #100, Individual #383, and Individual #406 who did not require goals/objectives, but did require OT/PT supports.

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

Summary: For the individuals reviewed, evidence was not found in ISP integrated reviews to show that OT/PT supports were implemented as required. These indicators will continue in active oversight.

			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/7	0/2	N/A	N/A	0/1	N/A	0/1	N/A	0/2	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the	0% 0/2	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A

	change.										

Comments: a. Overall, there was a lack of evidence in ISP integrated monthly reports that supports were implemented. OTs and PTs should work with QIDPs to ensure data are included and analyzed in ISP integrated reviews. The following provides examples of concerns noted:

- For Individual #469, the Integrated Progress Notes (IPNs) noted progress on his goals (i.e., increase ambulation distance, and demonstrate fair standing balance), but the ISP integrated monthly progress reports did not include any information with regard to these goals.
- Individual #150's ISP indicated the implementation of action plans for her goal for place-setting were due by 4/10/19. Based on a review of the documentation submitted, the IDT did not develop the SAP until 7/30/19, and no data were available by the time of this monitoring visit.
- For Individual #465, physical therapy IPNs included some evidence of implementation for his two therapy goals (i.e., improved lower extremity strength, and improved eye-hand coordination), but this was not carried over into ISP integrated monthly progress reports.
- Based on review of the documentation submitted, Center staff did not implement Individual #382's goal (i.e., putting cup on table) with the required frequency.

  In its comments on the draft report, the State disputed this finding, and stated: "Based on the most current OT/PT Assessment for #382 [sic], OT did not recommend the SAP of putting cup on table and instead recommended a different goal with supports on the annual OT/PT Assessment dated 5/23/19… IDT did not agree to implement the placing cup on the table goal based on documentation provided." However, in response to the Monitoring Team's document request for: "Skill Acquisition Programs related to OT/PT, including teaching strategies" (i.e., Document Request #97), Center staff provided a SAP related to the individual's use of the cup.

b. Based on review of ISPA documentation, the IDT for Individual #383 did not meet to discuss discontinuation of the boot used for her fractured ankle on 6/19/19. Similarly, Individual #406's IDT did not meet to discuss discontinuation of the float heel.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: It was good to see the Center had maintained good performance in this area since the previous review and should continue to focus on ensuring the proper fit of adaptive equipment, given its importance to the health and safety of individuals. This indicator will remain in active oversight. During future reviews, it also will be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	621	124	327	465	273	415	203	123	519

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.										
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.	93% 28/30	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		73	140	347	166	206	141	364	218	284
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		2/2	0/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		97	410	411	425	382	238	383	279	120
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		2/2	1/1	N/A	1/1	N/A	1/1	1/1	2/1	1/1
		Individuals:									
#	Indicator		178								
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 32 pieces of adaptive equipment. Based on observation of Individual #621 and Individual #140 in their wheelchairs, the outcome was that they were not positioned correctly. Individual #621's headrest was too far back to provide sufficient support for his head and neck, and this encouraged hyperextension. Individual #140's heels hit against the edge of his footrests, which could potentially be corrected with padding or extensions. 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. Four of these moved to, or were already in, the category requiring less oversight after the last review. Presently, 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.

It was good to see that many staff were knowledgeable about the risks and supports for each individual.

Overall, data were not reliable and monthly reviews did not summarize specific progress made towards goals, so it was not possible to determine if individuals were making progress and achieving goals. Per QIDP interviews and observations, none of the goals reviewed had been met.

Of the 155 action plans developed for the six individuals in the ISP review group, 42 had been (even partially) implemented.

None of the SAPs contained all of the required components, but many components were in every SAP.

Few SAPs were showing progress, perhaps due to implementation that was not frequent enough or not done as written. Even so, when an individual was not making progress, the Center did not take action, such as changing the methodology, doing further staff training, choosing a better SAP, etc.

Center staff should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner.

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 reliable, trusted data (or implementation), it is impossible to determine progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	563	469	463	444	150	411			

4	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/5		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% 0/5		0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/5		0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/5		0/6	0/6	0/6	0/6	0/6			

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

Of the 155 action plans developed for the six individuals in the ISP review group, 42 had been (even partially) implemented.

Individual #563's ISP was not scored for indicators 4-7. She had been newly admitted to the facility and her ISP had only been implemented for two months prior to the review. It was too early to determine what progress had been made or to expect goals to have been met.

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

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

Summary: It was good to see that many staff were knowledgeable about the risks and supports for each individual. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 563	469	463	444	150	411			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	67% 4/6	1/1	0/1	1/1	0/1	1/1	1/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

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

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

- For Individual #469 and Individual #444, observations did not support that staff were implementing their ISP and providing all supports needed to address risks.

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

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

Skill Acquisition and Engagement

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

Summary: Few SAPs were showing progress, perhaps due to implementation that was not frequent enough or not done as written. Even so, when an individual was not making progress, the Center did not take action, such as changing the methodology, doing further staff training, choosing a better SAP, etc. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 423	298	557	239	563	444	369	469	463
6	The individual is progressing on his/her SAPs.	20% 4/20	0/2	0/1	0/2	1/3		0/3	2/3	0/3	1/3
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.	6% 1/16	0/2	0/1	0/2	0/2		0/3	0/1	0/3	1/2
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 four of the SAPs that had reliable data.

These were the following: Individual #239 - sign basketball; Individual #369 - pedal cycle and get cup; and Individual #463 - put on shirt. Four SAPs were excluded from this analysis as there was not sufficient data to determine progress or the lack thereof. These were: Individual #298 - complete application; Individual #557 - critical thinking worksheets; and Individual #563 - rinse hair and phone mother.

Monitoring Team review of SAP implementation over a three-month period indicated that, on average, less than 75% of scheduled trials were implemented for 12 of the SAPs on which the individual was not making progress. These included the following: Individual #423 - yoga and money; Individual #298 - withdrawal form; Individual #557 - card game and multiplication; Individual #444 - set timer at work and emergencies; Individual #469 - stamp card and mail card; and Individual #463 - sing, phone call, and put on shirt.

7. The objective was not met in any of the SAPs.

8. There was evidence of action taken for one SAP, Individual #463's making a phone call. The Client SAP Training Progress Note indicated that this SAP had been revised in June 2019.

An ISPA noted that Individual #369's learning to sign more SAP had been discontinued. The IDT had agreed that a replacement SAP was not necessary at the time because he "still has plenty of SAPs to help him learn to be more independent." This SAP was intended to help him develop better communication skills, so it is suggested that a replacement SAP would have been appropriate.

Individual #469's stamp a card SAP had been put on hold due to his "behaviors and meds." It is suggested that observations should have first been completed to determine whether alternative strategies could be applied to foster progress.

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. Detailed comments are provided below regarding the four components most often not meeting criteria for this indicator. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463
13	The individual's SAPs are complete.	0% 0/24	0/2 13/20	0/2 14/20	0/3 16/28	0/3 18/ 29	0/2 15/20	0/3 22/ 29	0/3 21/30	0/3 15/30	0/3 25/ 30

Comments:
13. Because all 10 components are required for the SAP to be judged to be complete, the Monitor has provided a second calculation in the individual boxes above that shows the total number of components that were present for all of the SAPs chosen/available for review.

Although none of the SAPs were considered complete, over 75% of these contained the following elements: a task analysis where appropriate, a behavioral objective, an operational definition of the identified skill, a related discriminative stimulus, plans for maintenance and generalization, and documentation methodology.

Feedback on the remaining four components are provided below.

- There were several SAPs in which the individual was expected to complete a specific step in a chain. It was unclear how he or

she would ever be exposed to the complete chain. For example, Individual #423 was first learning to fold a yoga blanket. The instructions did not indicate how she would also learn the yoga exercises. Similarly, Individual #369 was supposed to learn how to pedal a cycle, however, the only step he was learning was to sit in a chair. The instructions did not clearly indicate how and when he would learn to perform this exercise. He was also learning to get a cup, but the only step he was exposed to was walking to the cabinet. In other cases, the focus of the SAP was unclear. For example, Individual #557 was to work on critical thinking, but other than completing a worksheet, critical thinking was not described. Instructions in other SAPs did not clearly identify the placement of materials, (e.g., Individual #298's application and withdrawal SAPs,) or the specific hand the individual should use to complete the skill (e.g., Individual #444's cut food SAP; Individual #469's brush teeth SAP; Individual #463's phone call SAP). Two SAPs that focused on communication skills (Individual #239 - sign basketball; Individual #369 - sign more) suggested teaching sign language in two steps. The full sign should be taught as one motion.

- Learning opportunities were often quite limited. Several SAPs indicated the days during which training would occur, but they did not indicate the number of expected trials. Examples included Individual #423's money SAP, Individual #557's worksheets and multiplication SAPs, Individual #239's pass a basketball and sign basketball SAPs, all three of Individual #444's SAPs, and Individual #369's pedal a cycle and sign more SAPs.
- In several SAPs, praise was the identified reinforcer for correct responding. Based upon observations during the onsite visit, it did not appear that praise from any person would function as a reinforcer. This was also supported when graphs indicated that the individual was not making progress in acquiring the skill.
- Consequences for incorrect responding were not always specific to the task. Several SAPs included generic guidelines that did not relate to the identified skill and as a result did not clearly identify how staff should respond. These included the following SAPs: all of Individual #557's SAPs, all of Individual #239's SAPs, all of Individual #369's SAPs, and the stamp card and mail card SAPs for Individual #469.

While onsite, a request was submitted for any assessments and/or recommendations provided by an Orientation and Mobility Specialist for Individual #444 and Individual #369. The Center reported that there was no information available at the time. As these two individuals have a significant visual impairment, it is important to ensure that all teaching programs include considerations and guidelines regarding the individual's sensory deficit. This was true for many of the individuals at the Abilene SSLC.

Outcome 5- SAPs are implemented with integrity.

Summary: Seven of the nine individuals refused to participate in their SAPs. This might be related to the regularity of SAP implementation. Two were eventually observed; one was implemented as written. The Center, however, showed that it checked SAP integrity at least twice each year. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 423	298	557	239	563	444	369	469	463
14	SAPs are implemented as written.	50% 1/2	Refused	Refused	Refused	Asleep	1/1	Refused	0/1	Refused	Refused
15	A schedule of SAP integrity collection (i.e., how often it is measured)	81%	2/2	0/2	3/3	3/3	2/2	2/3	3/3	2/3	3/3

	and a goal level (i.e., how high it should be) are established and achieved.	20/24									

Comments:

14. Although the Center staff had scheduled SAP observations at requested times, only two observations were completed. Six individuals declined to participate in the scheduled SAP training, either by verbally refusing (Individual #423, Individual #557, Individual #469, Individual #463) or by leaving the home (Individual #298, Individual #444). Individual #239 was asleep at the scheduled time and could not be awoken. The observations that were conducted are described below.

- The staff member implemented the phone SAP as written with Individual #563. Although a quiet room was selected, Individual #563 was quite distracted by the computer and other items present on the desktop. It would be helpful if staff could identify an area free of distracting materials and conduct more than one trial of this SAP each week.
- Although Individual #369 initially refused to get up from the couch to work on his cycling SAP, he did sit in the chair following repeated prompts. The staff member followed the SAP instructions, however, she did not offer him a lollipop upon completion of the task. It should be noted that she did provide praise and allowed Individual #369 to return to the couch, which appeared to be his primary interest.

15. Per state policy, SAP integrity should be assessed at a minimum of twice annually. Based upon the documentation provided, 20 of 24 SAPs had been monitored at acceptable levels over the six-month period prior to the onsite visit.

The exceptions included SAPs for which there was no evidence of monitoring (Individual #298 - withdrawal form; Individual #444 - set timer at work; and Individual #469 - stamp card) and SAPs in which integrity was poor (Individual #298 - application form). Three SAPs were on schedule to be monitored (Individual #557 - critical thinking worksheets; and Individual #563 - rinse hair and phone mother), however, because they had been implemented for less than three months, this had not occurred by the time of the onsite visit.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: Performance decreased from 100% at the last review to 74% and 88% for indicators 16 and 17. These indicators will remain in the category of requiring less oversight, but the Center should attend to this to ensure that performance does not slip further, and can even return to 100% or near 100%.			Individuals:								
#	Indicator	Overall Score									
16	There is evidence that SAPs are reviewed monthly.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
17	SAP outcomes are graphed.										
Comments:											

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.	
Summary: The Monitoring Team observed one-third of the individuals to be regularly meaningfully engaged in activities when observed. The Center's own data	Individuals:

for the review period was a bit higher, just over half meeting the Center's own engagement goals. These two indicators will remain in active monitoring.											
#	Indicator	Overall Score	423	298	557	239	563	444	369	469	463
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	0/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	56% 5/9	1/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1

Comments:

18. Three of the nine individuals were observed meaningfully engaged during the onsite visit. Individual #557 and Individual #563 were attending school, and Individual #298 was often working when he was observed.

For the other six individuals, engagement was generally poor. Individual #423 had very limited scheduled activities, although the Director of Education and Training reported that they were introducing her to music and exercise located in one of the activity centers. Individual #239 was observed with no or limited engagement in both his activity center and home environments. When visits were made to observe Individual #444, he was often asleep or eloping from his home. Individual #369 was often lying on the couch when at home. On only one visit to the gym was he actively engaged. Individual #469 was engaged only when in music class. Individual #463 was not engaged when observed in the senior center or at home.

The Director of Education and Training provided attendance records for the months of May 2019 through July 2019. The attendance records provided following the document request simply indicated whether the individual had arrived to his or her work or day program over a six-month period. These newer records noted the percentage of scheduled time that the individual remained at the site. A summary is provided below.

- Individual #423 - there were no scheduled activities indicated on her daily schedule.
- Individual #298 - scheduled for 31.5 hours of work each week, attended 58%-76% of time, mean of 67%.
- Individual #557 - attends school, no records of attendance provided.
- Individual #239 - scheduled for 22 hours at the activity center each week, attended 62%-82% of time, mean of 72%; scheduled for work 6.25 hours each week, attended 77%-105% of time, mean of 94%.
- Individual #563 - began school in August, no records of attendance provided.
- Individual #444 - scheduled for 2.5 hours of work each week, attended 27%-50% of time, mean of 38%.
- Individual #369 - scheduled for 10 hours at the activity center each week, attended 73%-102%, mean of 92%; scheduled for senior center 15 hours each week, attended 65%-89% of time, mean of 76%.
- Individual #469 - scheduled for 28 hours at the activity center each week, attended 24%-55% of time, mean of 44%; scheduled for senior center 3 hours each week, attended 22%-89% of time, mean of 44%.

- Individual #463 - scheduled for senior center 24 hours each week, attended 84%-87% of time, mean of 85%.

When scheduled activities are limited, when attendance is poor, or when participation is infrequent, the IDT should work to identify activities of interest and strategies to increase active engagement.

21. For five of the nine individuals, engagement goals were achieved in their homes and day program or work sites. These were Individual #423 (data for home only), Individual #557 (data for home only), Individual #563, Individual #369, and Individual #463. For the other four individuals, either assessments did not occur in both home and day/work sites each month and/or the scores did not meet the established goal levels.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.

Summary: With some attention, Abilene SSLC should be able to score higher on these indicators. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 423	298	557	239	563	444	369	469	463
22	For the individual, goal frequencies of community recreational activities are established and achieved.	38% 3/8	1/1	1/1	0/1	1/1		0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

22. All nine individuals had a goal frequency for community recreational activities identified in their ISP. These ranged from weekly outings to quarterly outings. The goal was achieved for three of eight individuals (Individual #423, Individual #298, Individual #239). Individual #563's goal had been established at quarterly outings, but she had only been in residence for less than three months at the time of the document request.

23. There was no evidence of community-based training for any of the nine individuals.

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.

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

Summary: Individual #557 and Individual #563 were attending school. Many aspects (sub-indicators) of this outcome were occurring, but not all of them yet. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	557	563							
25	The student receives educational services that are integrated with the ISP.	0% 0/2	0/1	0/1							

Comments:
25. By the time of the onsite visit, Individual #557 and Individual #563 were attending school. Many aspects (sub-indicators) of this outcome were occurring, but not all of them yet.

For Individual #557, there was evidence that both his QIDP and BCBA participated in his IEP meeting. During the IEP process, both inclusion and extended year services were reviewed. It was positive to review school-related information in his ISP, including action plans and SAPs to support his educational goals. Although reference was made to his school progress notes/report card in his QIDP Monthly Reports, there was no review of his performance. It was simply noted that there were no concerns. Individual #563 had been admitted to the Center at the end of May 2019, therefore, she had just begun attending school prior to the onsite visit. Her IEP meeting had not yet been held, therefore, there was no document to review. Although her ISP notes that her goal was to graduate from high school, staff are advised to amend her ISP once the team meeting has been held and her IEP had been developed.

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

#	Indicator	Overall Score	Individuals: 469	563	100	150	383	406	411	425	382
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the 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 e. None.

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: In many instances, individuals with communication needs did not have formal communication services and supports. As IDTs move forward with the development of such supports, it will be important to ensure the goals/objectives are both clinically relevant and measurable. SLPs should also work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	469	563	100	150	383	406	411	425	382
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her 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. through e. Based on a review of the documentation the Center submitted, IDTs should have developed communication goals for all nine individuals, but most individuals did not have goals/objectives. Some examples of missed opportunities for increasing individuals' communications skills included the following:

- The IDTs did not provide justifications for not developing goals/objectives to improve receptive language skills for Individual #469, Individual #100, Individual #150, and Individual #383.
- The IDTs for Individual #563 and Individual #150 did not address the use of augmentative and alternative communication (AAC) devices/supports, but should have based on their needs. For Individual #563, it was also unclear why programming was not developed to further expand her problem-solving, executive functioning, complex receptive language, and/or sequencing.
- For Individual #406, the IDT did not develop goals/objectives to expand and improve upon her many identified communication strengths (e.g. turn-taking, one-step requests, etc.), or provide a justification for not doing so.

The IDT for Individual #425 did develop a goal/objective (i.e., use a script to make a phone call) for him, but it was not clinically relevant, as the goal focused on reading a script rather than on having an actual conversation. In addition, the communication assessment did not clearly indicate this was a need as it stated that he is able to express himself through verbalizations. Therefore, it

was unclear why reading from a script would be considered an expansion of his skills. The goal/objective also was not measurable because it stated it would be achieved "for 100% accuracy," but did not indicate how often 100% would need to be achieved to demonstrate mastery (e.g., 100% accuracy for ten consecutive sessions). As a result, the related data could not be used to accurately measure the individuals' progress or lack thereof; still, it was positive the QIDP integrated progress report included some specific data and efforts at analysis.

In its comments on the draft report, the State disputed this finding, and stated: "The named support is not from SLP Assessment recommendation and should not be included in the Communication Section." In response to the Monitoring Team's document request for: "Skill Acquisition Programs related to communication, including teaching strategies" (i.e., Request #83), Center staff provided the SAP referenced in the draft report. Moreover, communication does not fall only under the domain of the SLPs, but impacts multiple areas of individuals' lives, and as such, requires interdisciplinary involvement in the development, and implementation of supports to address unmet needs. In addition, the SLP is part of the IDT, and should have been part of the discussion about this communication goals/objective. If it was not clinically appropriate to meet his needs, the SLP should have guided the IDT to consider a communication goal/objective that was relevant to address his needs.

The Monitoring Team completed full reviews for all nine individuals due to a lack of clinically relevant, achievable, and measurable goals, and a 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. These indicators will remain under active oversight.

#	Indicator	Overall Score	Individuals: 469	563	100	150	383	406	411	425	382
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/2	N/A	0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments. a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Examples of concerns with regard to the lack of evidence of implementation for measurable strategies and action plans included the following:

- For Individual #563, Center staff did not offer evidence that they provided the continued AAC assessment and direct therapy as recommended in the communication assessment.
- For Individual #425, integrated monthly progress reports indicated that Center staff were implementing the goal, but the reports did not contain a review of whether the individual was making progress toward improving the ability to hold a topic

and improve his ability to engage in a conversation.

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

Summary: The Center should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.

[**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]

#	Indicator	Overall Score	Individuals: 415	382	77	138	123	505	280	150	549
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	54% 7/13	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	25% 3/12	0/1	0/1	1/1	0/1	0/1	1/1	1/1	0/1	0/1

#	Indicator		Individuals: 305	3	263	239					
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	0/1	0/1	0/1					
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/1	0/1	0/1	N/A					
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	N/R									

Comments: a. It was concerning that often individuals' AAC devices were not present or readily accessible. Examples of concerns included the following:

- Devices for Individual #123 (i.e., Object Cue board), Individual #3 (i.e., wall mounted signs), and Individual #263 (i.e., wall mounted communication board) were available in some environments (e.g., bedrooms), but they were not readily available in other environments. This practice restricted the individuals' communication to certain environments.

  In its response to the document request, the State disputed this finding for Individual #123, and stated: "Individual #123-does not have an object cue board. SLP recommended utilizing functional real objects to help him understand since he is blind and

has a severe hearing loss…" In conducting observations, the Monitoring Team selects AAC equipment based off of a list that Center staff provide. Based on the list provided as well as staff interview, Individual #123 had an object cue board to request lotion, wipes, blanket, etc. As stated in the draft report, having these object cues only available in one location is not conducive to generalization.

In its comments on the draft report, the State disputed the finding with regard to Individual #3, and stated: "Regarding Individual#3: The wall mounted signs poster (on his bedroom door) is for Staff to understand some of his signs, not AAC for #3 [sic]. #3 [sic] is blind. Hab Therapy Note 11/13/18 documents when this was added as a support as follows: 'SLP and PNMPC mounted Sign Language List in #3's [sic] room for staff to use to understand his current and new signs. SLP and PNMPC trained staff members, supervisor and QIDP on home and also placed a temporary PNMP in his iBook. New PNMP will be on the home as soon as pictures are taken of the support and added, within two business days.' However, this document was not requested by the SAMT on-site and was not in the original document request." Based on the Monitoring Team member's interview with staff, they were not able to articulate the reason for the wall mounted signs. Regardless, the issue was that the support was not readily available, because it was attached to the wall.

The State also disputed the finding for Individual #263, and stated: "Regarding Individual #263: This gentleman's Current Speech Assessment Update dated 12/12/18 documents that communication boards are available in his bedroom, in the living room of his home and mounted on the wall of the activity center where #263 attends. However, this document was not requested in the document request nor requested on-site by SAMT." Similar to for Individual #3, the reason for the negative score was the mounting of the communication support on the wall, as well as the placement of the boards in only certain environments, which limits its functionality and/or the ability of the individual to effectively communicate throughout the environments in which he moves.

- For Individual #150 and Individual #549, Center staff did not ensure they had their communication books with them.
- It was concerning that Center staff often did not provide Individual #239 with his communication board unless he was engaging in a challenging behavior. This could potentially result in his learning that he needed to engage in the behavior in order to obtain access to his communication device.

b. When opportunities for using communication devices presented themselves, staff frequently 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. Prior to this review, one of these indicators moved to the category requiring less oversight. Based on information the Center provided, between the time of the Monitoring Team's last review and the onsite review, none of the individuals at Abilene SSLC transitioned to the community. As a result, none of the outcomes or indicators in Domain #5 were scored.

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: N/A			Individuals:									
#	Indicator	Overall Score										
1	The individual's CLDP contains supports that are measurable.	N/A										
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	N/A										
Comments: None.												

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
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.	N/A										
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.	N/A										
6	The PMM's assessment is correct based on the evidence.	N/A										
7	If the individual is not receiving the supports listed/described in the	N/A										

	CLDP, corrective action is implemented in a timely manner.										
8	Every problem was followed through to resolution.	N/A									
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A									
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A									
Comments: None.											

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score									
N	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.	N/A									
Comments: None.											

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: N/A			Individuals:								
#	Indicator	Overall Score									
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	N/A									
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	N/A									

	setting.										
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	N/A									
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	N/A									
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	N/A									
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	N/A									
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	N/A									
19	Pre-move supports were in place in the community settings on the day of the move.	N/A									
Comments: None.											

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	N/A										
Comments: None.												

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