United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

Dates of Onsite Review: November 16th to 20th, 2015

Date of Report: February 9, 2016

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed. The amount of documentation requested by the Monitoring Teams decreased with the changes in the way monitoring was being conducted.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Scoring** – The report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. The parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews. Therefore, none of the figures in this report should be construed as a statement regarding the Facility's compliance with the Settlement Agreement.

Organization of Report

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

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

Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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 Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	83% 10/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	80% 4/5	1/1	1/1	N/A	0/1	1/1	1/1	N/A	N/A	N/A

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (January 2015 through September 2015) were reviewed. In addition, following the onsite review, the facility submitted a narrative with additional information about many of these sets of data and graphs.

The data showed a decreasing trend of frequency of occurrence in the overall use of crisis intervention restraint over the nine months, ranging from about almost 40 per month for the first few months to less than 10 per month, on average, for the last few months. A similar decreasing trend was evident in the graph lines for the frequency and duration of physical crisis intervention restraints, and frequency of chemical restraints. Use of mechanical crisis intervention restraint remained low, at two occurrences over the nine months. The two occurrences were in the past three months.

Decreasing trend lines were also presented for the number of injuries that occurred as a result of crisis intervention restraint, the number of different individuals restrained for crisis intervention each month, and the number of individuals who received protective mechanical restraint for self-injurious behavior. This last category decreased from one to zero during this period.

The use of non-chemical or chemical restraint for dental procedures was low and stable. The use of non-chemical or chemical restraint for medical procedures, however, remained high, at about 100 times and 15 times per month, respectively. These numbers were higher than at other SSLCs. State office should ensure that all facilities are collecting and reporting on the same information for these variables.

Thus, state and facility data showed low usage and/or decreases in 10 of these 12 facility-wide measures (i.e., overall occurrence of crisis intervention restraint, frequency and duration of physical crisis intervention restraint, use of chemical or mechanical crisis intervention restraint, injuries occurring as a result of crisis intervention restraint, number of individuals restrained, use of protective mechanical restraint for self-injurious behavior, chemical and non-chemical restraint for dental).

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. All five were crisis intervention restraints (Individual #482, Individual #303, Individual #318, Individual #301, Individual #405). Data from state office and from the facility showed decreases in frequency or very low occurrences over the past nine months for four of the five (Individual #482, Individual #303, Individual #301, Individual #405). The frequency of crisis intervention restraint for Individual #318 was increasing over the nine months, though the most recent month had zero occurrences.

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

Also of note, the facility maintained a graph of the occurrence of crisis intervention restraint for the six individuals who had the most frequent restraint at the facility. Although restraint had not been eliminated for any, a decreasing trend was evident for all six.

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

			Individuals:								
#	Indicator	Overall Score	482	303	318	301	405				
3	There was no evidence of prone restraint used.	100% 7/7	2/2	1/1	1/1	2/2	1/1				
4	The restraint was a method approved in facility policy.	100% 7/7	2/2	1/1	1/1	2/2	1/1				
5	The individual posed an immediate and serious risk of harm to him/herself or others.	86% 6/7	1/2	1/1	1/1	2/2	1/1				
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 5/5	N/A	1/1	1/1	2/2	1/1				
7	There was no injury to the individual as a result of implementation of the restraint.	100% 7/7	2/2	1/1	1/1	2/2	1/1				
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 7/7	2/2	1/1	1/1	2/2	1/1				
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	100% 1/1	Not rated	Not rated	1/1	Not rated	Not rated				
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable	100% 6/6	2/2	1/1	1/1	1/1	1/1				

	manner.										
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	71% 5/7	2/2	0/1	1/1	1/1	0/1				

Comments:
The Monitoring Team chose to review seven restraint incidents that occurred for five different individuals (Individual #482, Individual #303, Individual #318, Individual #301, Individual #405). Of these, six were crisis intervention physical restraints, and one was a crisis intervention chemical restraint. The crisis intervention restraints were for aggression to staff or peers, self-injurious behaviors, suicidal actions, and/or dangerous unauthorized departure from the facility or from supervision. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

5. All restraints met criterion for this indicator except for Individual #482 7/29/15. The restraint was used to prevent unauthorized departure. The restraint documentation indicated that she walked out the back gate, but it needed further elaboration regarding how this was a crisis situation for which restraint was necessary.

9. Because criterion for indicator #2 was met for Individual #482, Individual #303, Individual #301, and Individual #405, this indicator was not scored for them. For Individual #318, supports were in place and being implemented (e.g., PBSP).

11. The IRRF section of the ISP did not show a selection of one of the two options in the template to document restraint considerations for Individual #303 and for Individual #405.

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

			Individuals:								
#	Indicator	Overall Score	482	303	318	301	405				
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	60% 3/5	1/1	0/1	1/1	1/1	0/1				

Comments:
12. Some staff were unable to report that prone restraint was a prohibited type of restraint.

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

			Individuals:								
#	Indicator	Overall Score	482	303	318	301	405				
13	A complete face-to-face assessment was conducted by a staff member	71%	2/2	1/1	0/1	1/2	1/1				

	designated by the facility as a restraint monitor.	5/7									
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A				

Comments:
13. Five restraints met criterion for this indicator. Two did not meet criterion. They were Individual #318 8/24/15, for which the restraint was initiated at 7:32 pm and the restraint monitor arrived at 8:08 p.m., just beyond the required time; and for Individual #301 3/27/15, for which the restraint was initiated at 7:00 am and the restraint monitor arrived at 1:30 pm.

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

			Individuals:								
#	Indicator	Overall Score	482	303	318	301	405				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	14% 1/7	0/2	0/1	0/1	1/2	0/1				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	100% 7/7	2/2	1/1	1/1	2/2	1/1				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	29% 2/7	0/2	0/1	1/1	1/2	0/1				

Comments: a. The crisis intervention restraints reviewed included those for: Individual #482 on 7/29/15 at 10:58, and 4/17/15 at 4:32 p.m.; Individual #303 on 4/13/15 at 4:34 p.m.; Individual #318 on 8/24/15 at 7:45 p.m.; Individual #301 on 9/29/15 at 7:47 p.m., and 3/27/15 at 7:00 a.m.; and Individual #405 on 3/11/15 at 4:40 a.m. The restraint for which necessary nursing assessments were performed was the off-grounds restraint for Individual #301 on 9/29/15.

b. It was positive to see that restraint-related injuries or other negative health effects were documented.

c. The restraints for which nursing staff took action to meet the individual's needs were the ones for Individual #318 on 8/24/15 at 7:45 p.m.; and Individual #301 on 9/29/15 at 7:47 p.m.

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

			Individuals:								
#	Indicator	Overall Score	482	303	318	301	405				
15	Restraint was documented in compliance with Appendix A.	86%	1/2	1/1	1/1	2/2	1/1				

		6/7									

Comments:
15. All restraints met criterion for this indicator, except for the chemical crisis intervention restraint for Individual #482 4/17/15. The name(s) of who applied the restraint on the restraint checklist did not include a nurse, which is what is typically seen in the administration of chemical crisis intervention.

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

			Individuals:								
#	Indicator	Overall Score	482	303	318	301	405				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	86% 6/7	1/2	1/1	1/1	2/2	1/1				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	N/A	N/A	N/A	N/A	N/A	N/A				

Comments:
16. A thorough review of the restraint was conducted for this set of restraints, except for Individual #482 7/29/15. The review was inconclusive with respect to the emergency nature of this restraint. This issue should have been identified and addressed in context of facility review process.

17. Because recommendations were not made, this indicator was not scored. While onsite, the Monitoring Team talked with the facility about its review and recommendation process, which seemed sufficient.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.

			Individuals:								
#	Indicator	Overall Score	482	303	301	405	525	98	549		
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	77% 10/13	2/2	1/2	3/3	0/1	1/1	1/2	2/2		

Comments:
The Monitoring Team reviewed 13 investigations that occurred for seven individuals. Of these 13 investigations, seven were DFPS investigations of abuse-neglect allegations (two confirmed, four unconfirmed, one inconclusive). The other six were for facility investigations of serious injury, suicidal action, sexual incident, and/or unauthorized departure. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the

Monitoring Team to evaluate the response to a variety of incidents.

- Individual #482, 4/26/15, physical abuse allegation, unconfirmed, DFPS #43737596, UIR #3394
- Individual #482, 6/26/15, suicidal actions, UIR #3482
- Individual #303, 7/16/15, neglect allegation, confirmed, DFPS #43848597, UIR #3536
- Individual #303, 3/8/15, unauthorized departure off campus, UIR #3134
- Individual #301, 3/6/15, neglect allegation, unconfirmed DFPS #43571863, UIR #3133
- Individual #301, 6/9/15, sexual incident, UIR #3443
- Individual #301, 7/7/15, unauthorized departure off campus, UIR #3517
- Individual #405, 6/10/15, verbal/emotional abuse allegation, unconfirmed, DFPS #43767059, UIR #3445
- Individual #525, 7/22/15, serious injury, UIR #3564
- Individual #98, 6/23/15, neglect allegation, unconfirmed, DFPS #43801977, UIR #3474
- Individual #98, 4/9/15, serious injury, UIR #3276
- Individual #549, 8/9/15, physical abuse allegation, confirmed, DFPS #43923145, UIR# 3676
- Individual #549, 3/31/15, physical abuse allegation, inconclusive, DFPS #43598433, UIR #3238

1. For all 13 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes the occurrence of staff criminal background checks and signing of duty to report forms; facility and IDT review of trends; and the development, implementation, and revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and Quality Assurance Director met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For 10 of the 13, the facility met the criteria for this indicator by having protections in place. That is, criminal background checks were conducted (13/13), staff signed the annual acknowledgement of their reporting responsibilities (12/13), trends/prior occurrences were identified (8/9) or there were no trends or prior occurrences (4/4), a plan was developed and implemented (9/9), and the plan was revised if it was not effective (4/6).

The three that did not meet all of the criteria were Individual #405 UIR 3445 because a staff member who worked with him had not signed the acknowledgement form within the past year as required and another staff member's date was illegible; Individual #303 UIR 3536 because although behavioral health services had begun to review of trends/prior occurrences of behavior problems, the IDT was not involved and revisions were not made to his plan; and Individual #98 UIR 3474 because actions to address his safety from one of his peers was discussed, but not implemented. In its response to the draft report, the State pointed to actions taken by the facility immediately following the incident regarding Individual #98. This was good to see and is reflected in scoring for the indicators below. This indicator looks for whether protections were in place at the time of the incident if trends relating to the incident were identified. And, if a plan (i.e., protections) were in place, was it implemented and revised if not effective.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
			Individuals:								
#	Indicator	Overall Score	482	303	301	405	525	98	549		
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	38% 5/13	0/2	1/2	2/3	0/1	0/1	1/2	1/2		

Comments:

2. The Monitoring Team rated three of the investigations as being reported correctly. The others were rated as being reported late. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator. Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #482, UIR 3394, per DFPS, the incident occurred on 4/26/15 and was reported to DFPS on 5/28/15 at 4:24 pm. Per the UIR, it occurred on 4/25/15 and was reported to the facility director on 5/29/15. There was nothing in the UIR that explained this late reporting. The UIR should have identified and described the circumstances associated with the late reporting.
- Individual #482, UIR 3482, the UIR showed that a suicide risk assessment was completed and that her attempt was deemed credible at 2:25 am. It was reported to the facility director at 3:48 am.
- Individual #303, UIR 3536, the DFPS report showed that the incident occurred on 7/16/15 at 8:30 am and was reported to DFPS on 7/20/15 at 9:53 am. DFPS subsequently sent the allegation back to the facility director on 7/20/15 at 10:19 am. But the UIR showed facility director notification on 7/16/15 at 2:30 pm. The language in the DFPS intake suggested that the report on 7/20/15 was made by facility staff who, if suspicious of neglect, should have reported this earlier. Most importantly, there was no language in the UIR (or any of the incident review documents) that attempted to address or reconcile this apparent late reporting.
- Individual #301, UIR 3443, the UIR showed that the incident occurred at 6:50 pm and was reported to the facility director at 8:08 pm.
- Individual #405, UIR 3445, the DFPS report showed that the incident occurred on 6/10/15 and was reported to DFPS on 6/11/15. The UIR showed facility director notification on 6/11/15. Although the anonymity of the reporter is maintained by DFPS, if it appears that the reporter was another staff person who either witnessed the event or knew of it and did not immediately report, this should be noted and follow-up actions taken.
- Individual #525, UIR 3564, in the injury report, the fracture was confirmed at 3:00 pm on 7/19/15. It was reported to the facility director on 7/22/15. Once a fracture is confirmed, it is evident that it is a serious incident that needs to be reported immediately by whomever has the knowledge that a fracture has been confirmed. That is, staff should not be waiting for the coding by a physician. In this case, the individual had an x-ray, a confirmed fracture, and the fingers buddy-taped. A confirmed fracture should be immediately reported to the facility director in order to assess the immediate need for implementation of any protection measures. Further, this individual had been the subject of two previous abuse/neglect investigations related to serious injuries in the last year.

- Individual #98, UIR 3474, the DFPS report showed that the incident occurred on 6/23/15 and was reported to DFPS on 6/29/15. According to the UIR, the incident occurred on 6/23/15 at 4:12 pm and was reported to the facility director at 8:37 pm; within one hour of determination that it was a serious injury. The UIR did not have any explanation as to why it was not immediately reported to DFPS. In its response to the draft report, the State stated that ANE was not suspected by the facility. Even so, it was more likely that some staff person who saw or was aware of the incident that resulted in the fractured hip (from peer-to-peer aggression) reflected on this and thought it represented neglect in the supervision of both individuals and reported it six days after it occurred. Facility exploration of this time gap would likely have resulted in the taking of actions to persistently train and retrain staff on reporting immediately.
- Individual #549, UIR 3676, the DFPS report stated that the incident occurred on 8/9/15 and was reported to DFPS on 8/25/15. The UIR stated that the incident occurred on 8/9/15 and that the facility director notification was on 8/25/15. This incident was reported after video review of a restraint. The UIR, however, did not show the date/time of the video review, therefore, the Monitoring Team could not determine if it was reported within one hour of identification on the video.

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

			Individuals:								
#	Indicator	Overall Score	482	303	301	405	525	98	549		
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	50% 2/4	Not scored	1/1	Not scored	1/1	0/1	0/1	Not scored		
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	71% 5/7	1/1	1/1	1/1	1/1	0/1	1/1	0/1		
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	92% 12/13	2/2	2/2	3/3	0/1	1/1	2/2	2/2		

Comments:

3. This indicator was not scored for three individuals because criterion was met for indicator #1 regarding protections being in place. For the other four, two met criterion for this indicator. For the other two, Individual #525 and Individual #98, their staff stated that abuse allegations should be reported to her supervisor, or the staff was not sure how to report unusual incidents.

4. Individual #525 and Individual #549 did not attend their ISP meetings, nor did their LARs. Action plans to share information with the LARs were written, but not implemented. Although criterion was met for Individual #482 for educating individuals and LARs, she had 43 allegations listed in her ISP, but no discussion occurred.

5. Individual #405, UIR 3445, the alleged victim, responded three times to the DFPS investigator's questions by stating "afraid." In reviewing the DFPS investigation, the facility should have identified this and probed further with regard to fear of retaliation.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
			Individuals:								
#	Indicator	Overall Score	482	303	301	405	525	98	549		
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 13/13	2/2	2/2	3/3	1/1	1/1	2/2	2/2		
Comments: 6. For Individual #303 UIR 3536, the UIR did not show any immediate actions taken after receiving information on the allegation despite three alleged perpetrators being named and that the reported incident included an injury to the individual. During the onsite review, the facility acknowledged that this was not addressed in the UIR, but that there were emails showing they were re-assigned, which were presented to the Monitoring Team. Nonetheless, the UIR is considered the official investigation report and should contain all relevant information, especially such a critical piece of information as alleged perpetrator reassignment.											

Outcome 5– Staff cooperate with investigations.											
			Individuals:								
#	Indicator	Overall Score	482	303	301	405	525	98	549		
7	Facility staff cooperated with the investigation.	100% 13/13	2/2	2/2	3/3	1/1	1/1	2/2	2/2		
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
			Individuals:								
#	Indicator	Overall Score	482	303	301	405	525	98	549		
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	54% 7/13	1/2	1/2	1/3	1/1	0/1	1/2	2/2		
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	54% 7/13	1/2	1/2	1/3	1/1	0/1	1/2	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)	54% 7/13	1/2	1/2	1/3	1/1	0/1	1/2	2/2		
Comments: 8. In the six facility-only investigations, there was no indication that staff who were involved in the incident were interviewed or that											

the content of any statements (if any were taken) were used in the investigation. Three of these six contained a statement, "After reviewing witness statements…," however, a summary of the content was not provided. Two others noted the number of staff who were involved, but nothing about whether they were interviewed and if so what the content was. For one, there was no mention of staff interview.

9. Failure to collect all relevant evidence (i.e., staff interview detail) resulted in the six investigations not meeting criterion for this indicator.

10. The analysis of findings in the UIR was generally acceptable, but without the content from staff interviews, it was not clear if or how that that evidence was used in the findings and conclusions of the facility-only investigations.

Outcome 7– Investigations are conducted and reviewed as required.

			Individuals:								
#	Indicator	Overall Score	482	303	301	405	525	98	549		
11	Commenced within 24 hours of being reported.	100% 13/13	2/2	2/2	3/3	1/1	1/1	2/2	2/2		
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 13/13	2/2	2/2	3/3	1/1	1/1	2/2	2/2		
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	15% 2/13	0/2	0/2	1/3	0/1	0/1	0/2	1/2		

Comments:
11-12. Investigations commenced and were completed within the expected timelines.

13. The supervisory reviews did not address issues of late reporting, or the lack of staff interviews being described in the UIR. Therefore, these investigations and/or these investigation reports (the UIRs) were not thorough and complete, and the review was not adequate. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.											
			Individuals:								
#	Indicator	Overall Score	482	303	301	405	525	98	549		
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	50% 2/4	N/A	N/A	1/1	N/A	1/2	0/1	N/A		

Comments:

15. There were non-serious injury investigations for NSIs for Individual #301, Individual #525, and Individual #98. The data item regarding whether or not abuse/neglect was suspected (circle a yes or no) was not completed for one of two for Individual #525 and for Individual #98.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
			Individuals:								
#	Indicator	Overall Score	482	303	301	405	525	98	549		
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	15% 2/13	0/2	0/2	1/3	0/1	0/1	0/2	1/2		
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	86% 6/7	1/2	2/2	1/1	N/A	N/A	1/1	1/1		
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 10/10	2/2	2/2	3/3	N/A	1/1	1/1	1/1		

Comments:

16. The investigations did not contain recommendations for corrective actions regarding the various aspects of the investigations noted in the above indicators (e.g., late reporting, lack of information regarding interview content, no follow-up on alleged victim being afraid). To reiterate, these other indicators did not meet criteria because the investigation did not address these issues (indicators 2, 5, 8, 9, 10) and/or the supervisory review did not identify the issues (indicator 13). This indicator is concerned with there being recommendations to address all findings and concerns.

17. Seven of the investigations involved disciplinary or other employee action. Six occurred in a timely manner.
    - For Individual #482 UIR 3394, the investigation results recommended that behavioral health services staff engage in a variety

of actions. No evidence of this occurring was provided, such as staff meeting minutes or an email to behavioral health services staff.

For Individual #549 UIR 3676, DFPS confirmed physical abuse (class 2) by one employee for use of an unapproved restraint method. The employee was not discharged; she received a letter of reprimand. The facility correctly followed state policy, that is, the facility used its own discretion to consider various factors in determining whether termination or another action was most appropriate for this situation, and it included the state office director of operations and the state office incident management coordinator in making this determination. The Monitoring Team offers a suggestion that state office consider whether confirmations of class 2 abuse should have a minimum level of disciplinary action, or a process whereby, if the facility deems the confirmation to not be serious, that it appeal the DFPS finding, as allowed by policy.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes									
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.	Yes									
23	Action plans were appropriately developed, implemented, and tracked to completion.	Yes									

Comments:
19-23. The facility met the criteria for these indicators. However, given the problems identified in the above outcomes and indicators regarding incident management, the Monitoring Team recommends that the IMC and the QA department track the performance regarding the conduct and content of investigative activities, follow-up, and documentation.

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)											
			Individuals:								
#	Indicator	Overall Score	482								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/1	0/1								
48	Multiple medications were not used during chemical restraint.	100% 1/1	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	100% 1/1	1/1								
Comments: 47-49. One restraint was reviewed for this outcome. It was for Individual #482; review by the pharmacist and psychiatrist was delayed. The other two indicators met criteria.											

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	N/A									
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered TIVA/general anesthesia for dental treatment. b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.											

Outcome 9 – Individuals receive medical pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	80% 4/5	N/A	N/A	4/4	N/A	N/A	0/1	N/A	N/A	N/A
Comments: None.											

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
			Individuals:								
#	Indicator	Overall Score	441	405	525	98					
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	100% 4/4	1/1	1/1	1/1	1/1					
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	100% 4/4	1/1	1/1	1/1	1/1					
3	Action plans were implemented.	0% 0/4	0/1	0/1	0/1	0/1					
4	If implemented, progress was monitored.	0% 0/4	0/1	0/1	0/1	0/1					
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/4	0/1	0/1	0/1	0/1					
Comments: 1-5. The ISPs for four individuals (Individual #441, Individual #405, Individual #525, Individual #98) indicated that PTS was utilized. Each of these individuals had a Medical Restraint Plan that included informal strategies to prevent the use of PTS. These included having familiar staff accompany the individual, providing preferred items, and scheduling for the best time of day. There were no formal plans developed to minimize or eliminate the need for PTS and implementation of the informal plans was not recorded nor the outcome assessed. Individual #525 had been referred on 7/25/15 to behavioral health services for initial assessment regarding a desensitization plan, but this had not been completed at the time of the visit.											

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.	
	Individuals:

#	Indicator	Overall Score	1	343	386	466					
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.	100% 4/4	1/1	1/1	1/1	1/1					

Comments: a. Since the last review, five individuals died. The Monitoring Team reviewed four of these deaths. The fifth individual died shortly before the Monitoring Team's onsite review, so complete mortality review and follow-up documentation was not yet available. Causes of death were listed as:

- For Individual #1, acute on chronic systolic heart failure, and chronic recurring sigmoid volvulus;
- For Individual #343, septic shock, peritonitis, chronic ileus, and mega colon;
- For Individual #386, septic shock with renal failure; and
- For Individual #466, septic shock aspiration pneumonia, dysphagia, and Down syndrome.

b. through d. Facility staff had not conducted sufficient review to conclude that necessary recommendations had been identified across disciplines. For example, fairly comprehensive nursing reviews of the records of individuals who died were completed in the past, but such reviews had not been completed for any of the individuals the Monitoring Team reviewed during this current review. Without thorough interdisciplinary reviews, the mortality reviews will not have the desired impact on Facility practices.

In addition, as discussed in more detail below, recommendations were not written in a manner that ensured the desired changes actually occurred.

e. Based on the recommendations as they were written, evidence was present to show that they were completed. Unfortunately, the recommendations were not written in a way that ensured that Facility practice had improved. For example, a recommendation that read: "address incomplete/inaccurate /inconsistent BM [bowel movement] log documentation" resulted in reminders to nursing staff in staff meetings about BM documentation. This in no way ensured that inconsistent practices changed. The recommendation should

have been written in a manner that required closure to include monitoring to determine whether or not practice was consistent with BM log documentation requirements.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	ADRs are reported immediately.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/1	0/1								
c.	Clinical follow-up action is taken, as necessary, with the individual.	100% 1/1	1/1								
d.	Reportable ADRs are sent to MedWatch.	100% 1/1	1/1								
Comments: a. through d. In its response to the draft report, the State indicated: "It is not clear how the monitoring team arrived at this score for Individual #7, since Pharmacy and Therapeutics Committee Meeting Minutes were neither requested nor provided in either the Pre-visit or Onsite document request. The ADR was discussed by committee members at the 11/12/15 meeting, as documented in the meeting minutes. Please score this as N/A since the documents were not requested by monitoring team." However, the State's assertion was incorrect, because the Monitoring Team clearly requested the following in the pre-review request (i.e., #36): "Adverse Drug Reaction Forms and follow-up documentation." Given the very specific requirement that ADRs be reviewed to determine whether or not they need to be reported to MedWatch, Pharmacy and Therapeutics minutes are part of the follow-up for ADRs at SSLCs, and the Facility should have submitted the relevant one, but did not. The Monitoring Team's original finding stands.										

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 4/4
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 4/4
Comments: a. and b. Abilene SSLC completed four DUEs, including: • In April 2015, a follow-up study on Tegretol (i.e., the original was conducted in November 2014); • In April 2015, a follow-up study on Mupirocin (i.e., the original was done in January 2015); • In April 2015, a follow-up study on ferrous sulfate (i.e., the original was conducted in January 2015); • In July 2015, a study of Acetaminophen with follow-up completed in November 2015.		

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

ISPs

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

			Individuals:								
#	Indicator	Overall Score	303	301	525	98	23	7			
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	0/6	0/6	0/6	0/6	0/6	1/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 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 #98, Individual #525, Individual #303, Individual #301, Individual #23, and Individual #7. The monitoring team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Abilene SSLC campus. Six components of the ISP are monitored: recreation/leisure, relationships, employment/day, independence, living options, and health.

1. Most outcomes for individuals remained very broadly stated and general in nature. Goals did not identify preferences for specific day activity or living options and, in many instances, did not offer an opportunity to learn new skills. For example, Individual #303's living option goal stated "will be provided with opportunities for community involvement." Individual #525's leisure goal stated "will be provided the opportunity to participate in activities that are important to him and he enjoys."

2. Goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting goals had been achieved. Examples of personal goals that were not measurable included Individual #7's greater independence goal to increase his independence in the areas of communication and engagement and Individual #23's day/employment goal to attend Seniors Program with his peers from his home.

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

and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

3. Review of data implementation sheets and QIDP monthly reviews indicated that data were not available for most ISP action plans. Monthly reviews of services and supports noted gaps in implementation and data collection for all of the individuals. In some cases, it was noted that goals were never fully implemented during the ISP year.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
			Individuals:								
#	Indicator	Overall Score	303	301	525	98	23	7			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1			
10	ISP action plans supported the individual's overall enhanced independence.	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1			
11	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			
18	Each ISP action plan provided sufficient detailed information for	0%	0/6	2/6	1/6	2/6	0/6	1/6			

	implementation, data collection, and review to occur.	0/6									

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

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

9-10. Preferences and opportunities for choice were not well-integrated in the individuals' ISPs. Individuals had limited opportunities to learn new skills based on identified preferences. In most cases, there was no discussion regarding specific preferences for day programming. ISPs defined day programming by where the individual would receive services (e.g., Seniors, Activity Center), however, skill building opportunities were not defined. ISPs did not include discussion regarding opportunities for choice throughout the day.

There were some exceptions. Individual #301's ISP did provide opportunity for her to engage in work based on her preferences and the team developed a SAP for self-management of her schedule. Individual #7 had a SAP to use a communication device to exercise some control over his day. Supporting individuals to make choices and express preferences would be a first step in the IDT determining individual preferences for living options and day programming.

11. Without well-defined personal goals, it was difficult to determine if action plans would support the individuals to be more independent. Action plans to support independence were often not measurable, thus, it was unlikely that consistent implementation would occur. Individual #23's action plans focused on regaining his mobility, which would allow him to be more independent. Individual #7's SAP for use of a communication device provided him increased independence in initiating contact with others.

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

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. Individual #303's IDT, however, did integrate communication and behavioral strategies into teaching methodologies for his skill acquisition plans.

14. ISPs included generic opportunities to visit in the community, but there was a lack of focus on specific plans for community participation that would have promoted any meaningful engagement or integration.

15. Action plans to support work and day programming did not address skills that were required for jobs or activities based on the individual's preferences. There was little consideration of what the individual wanted to learn or do during the day. Individuals did not have opportunities to explore employment options or learn work skills that might transfer into a more integrated setting.

16. One individual (Individual #301) had substantial opportunities for functional engagement and was consistently engaged in functional activity during observations. Individual #23 did not have any action plans to support his day/employment goal.

17. Two of the ISPs addressed barriers to achieving goals. Documentation indicated that action plans and supports were not regularly implemented or monitored for any of the individuals. IDTs did not meet to discuss barriers to implementation. Individual #23 and Individual #7 had action plans to address mobility and medical issues that were identified barriers to achieving goals.

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

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
			Individuals:								
#	Indicator	Overall Score	303	301	525	98	23	7			
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).	50% 3/6	1/1	1/1	0/1	0/1	0/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	1/1	0/1	0/1	0/1	0/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6	1/1	1/1	1/1	0/1	0/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	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	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Three of six ISPs included a description of the individual's preference and how that was determined. Those that did described preferences based on what the IDT could identify as preferences in the current environment and what supports should be in place.

21. Five of the six ISPs included recommendations from all relevant supports staff. For Individual #98, nursing and habilitation therapy assessments did not include a recommendation.

22. Five of the six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. The exception was Individual #301's ISP.

23. Two individuals (Individual #303 and Individual #7) had a thorough examination of living options based upon their preferences, needs, and strengths.

24. Four of the six 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 #98's ISP identified LAR choice as an obstacle to referral, however, the living option discussion noted that his LAR would consider his living closer to her. Individual #23's ISP indicated that needed medical supports were not available in the community, however, the IDT failed to identify which medical supports were not available.

26. One of the ISPs (Individual #7) included measurable action plans to address barriers to referral.

28. None of the ISPs included action plans to educate individuals or LARs about community living options.

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

			Individuals:								
#	Indicator	Overall Score	303	301	525	98	23	7			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6	1/1	1/1	0/1	1/1	0/1	1/1			

34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

Comments:
30. ISPs were revised every year.

32. Due to the lack of data available, the Monitoring Team was unable to confirm that ISPs were fully implemented within 30 days of development.

33. Four of the six individuals attended their ISP meetings. The exceptions were Individual #525 and Individual #23.

34. One of the individuals had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
			Individuals:								
#	Indicator	Overall Score	303	301	525	98	23	7			
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.	67% 4/6	1/1	1/1	1/1	0/1	0/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			

Comments:
35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP Preparation meeting for four of the six individuals. For Individual #525 and Individual #23, the IDT did not recommend updated habilitation therapy assessments even though both had experienced relevant changes in status since the last assessment.

36. According to assessment submission data provided by the facility, one (Individual #301) of six individuals had all needed assessments available 10 days prior to the annual ISP meeting for planning purposes.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
			Individuals:								
#	Indicator	Overall Score	303	301	525	98	23	7			
37	The IDT reviewed and revised the ISP as needed.	17%	0/1	0/1	0/1	0/1	1/1	0/1			

		1/6									
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

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

38. QIDPs were not reviewing services and supports monthly. The Monitoring Team requested QIDP monthly reviews for the past six months for each individual. There was no clear evidence that these reviews had been completed on a monthly basis.

- The facility reported that QIDP monthly reviews were not available for Individual #98 and Individual #525.
- One month of monthly reviews was submitted for Individual #301 and Individual #23.
- For Individual #303, May 2015 through August 2015 QIDP monthly reviews were identical. June 2015 through August 2015 monthly reviews were all signed and dated 8/24/15.
- Monthly reviews were submitted for Individual #7, however, no data were available to determine progress or regression. Attendance data for day programming was conflicting from month to month.

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

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	The IDT uses supporting clinical data when determining risks levels.	22% 4/18	0/2	1/2	0/2	0/2	2/2	1/2	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.	11% 2/18	0/2	0/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #7 – constipation/bowel obstruction, and polypharmacy/side effects; Individual #23 – respiratory compromise, and UTIs; Individual #69 – skin integrity, and fractures; Individual #347 – constipation/bowel obstruction, and fractures; Individual #466 – behavioral health, and falls; Individual #525 – dental, and constipation/bowel obstruction; Individual #261 – UTIs, and constipation/bowel obstruction; Individual #98 – falls, and cardiac disease; and Individual #150 – constipation/bowel obstruction, and falls).

a. The IDTs that effectively used supporting clinical data and used the risk guidelines when determining a risk level were those for Individual #23 – respiratory compromise; Individual #466 – behavioral health, and falls; and Individual #525 – dental.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate.

Psychiatry

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
4	The individual has goals/objectives related to psychiatric status.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1

Comments:
4-7. The psychiatry staff monitored problem target behaviors, such as aggression and self-injury, and they implemented interventions and/or made adjustments to the psychiatric treatment plan when necessary. Individuals, however, were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status.

In its response to the draft report, the State pointed to goals being in the quarterly reviews for seven individuals and in the CPE for the eighth individual, and also that the linking of the psychiatric diagnosis to specific target behaviors being in the psychiatric treatment plans and IRRFs. The goals in indicators 4 thru 7 were intended to be comprehensive goals that took into account the individual's psychiatric diagnosis, the symptoms of that diagnosis, and the elucidation of the linkage between those symptoms and the overt behaviors that are identified as the target behaviors. The Monitoring Team was also looking for the inclusion of goals related to the positive aspects of the individual's behavior. The rationale for this addition was to ensure that the negative target behaviors were not simply being suppressed by the prescribed medications. These goals were also to be approved by the IDT and included in the ISP. These types of goals were not evident for each individual. The Monitoring Team's understanding is that the state office will be working with each facility on the types of goals that can meet criterion.

The director of the psychiatry department reported that a wellness rating scale was being tried. It was to be done once a quarter and it involved obtaining consensus of the subjective opinions of staff present at the quarterly review. It is very possible that the use of this

type of tool will not meet the requirements of this outcome because it was not individualized and because of the subjectivity of the way the data were obtained. The Monitoring Team recommends that the facility work with state office coordinators for psychiatry and behavioral health.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
12	The individual has a CPE.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
13	CPE is formatted as per Appendix B	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
14	CPE content is comprehensive.	63% 5/8	1/1	0/1	1/1	0/1	0/1	1/1	1/1	N/A	1/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 2/2	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	63% 5/8	0/1	1/1	0/1	1/1	1/1	1/1	0/1	N/A	1/1

Comments:
14. The Monitoring Team looks for 14 components to be in the CPE. Five of the CPEs were rated as being complete. Three of the older CPEs were missing the important components of sufficient discussion of the psychological/behavioral aspects of the individual's presentation and the resultant formulation and treatment planning recommendations (Individual #303, Individual #318, Individual #301).

16. The consistency of the diagnoses throughout the record was evident for five individuals. For the others, diagnoses varied across documents or were not correctly updated at subsequent document updates (Individual #482, Individual #441, Individual #525).

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
17	Status and treatment document was updated within past 12 months.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	N/A

		7/7									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 6/6	1/1	1/1	N/A	1/1	1/1	1/1	1/1	N/A	N/A
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	86% 6/7	1/1	1/1	N/A	1/1	1/1	1/1	0/1	N/A	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	57% 4/7	1/1	0/1	N/A	1/1	1/1	1/1	0/1	N/A	0/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	43% 3/7	0/1	0/1	N/A	1/1	1/1	1/1	0/1	N/A	0/1

Comments:

17. Abilene SSLC used a document called the Psychiatric Treatment Plan (PTP) as the annual review and update prepared by the psychiatry department for the annual IDT ISP review.

18. The Monitoring Team scores 16 aspects of the annual document. The PTPs were complete and of good quality.

19. Individual #525's PTP was submitted after the ISP meeting.

20. The Monitoring Team noted an overall improvement in psychiatry attendance at ISP meetings. Facility wide data showed attendance at all but a few ISPs over the past year.

21. The quality of the information regarding psychiatry was very good in the ISP (as noted in this report in other indicators), however, documentation of psychiatry participation in the ISP varied. Criterion was met for Individual #318, Individual #301, and Individual #405.

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

22. PSPs were not used for any individuals at Abilene SSLC.

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

			Individuals:								
#	Indicator	Overall	482	303	441	318	301	405	525	98	549

		Score									
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	63% 5/8	0/1	0/1	1/1	1/1	1/1	1/1	1/1	N/A	0/1
29	The written information provided to individual and to the guardian was adequate and understandable.	75% 6/8	0/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	0/1
30	A risk versus benefit discussion is in the consent documentation.	75% 6/8	0/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	0/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	75% 6/8	0/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	0/1
32	HRC review was obtained prior to implementation and annually.	25% 2/8	0/1	0/1	1/1	1/1	0/1	0/1	0/1	N/A	0/1

Comments:
Much of the documentation was not provided to the Monitoring Team as part of the standard Monitoring Team document request. Therefore, the Monitoring Team requested these documents while onsite. In the future, these documents should be included in the original document request as part of the typical monitoring review process.

28. For three individuals, consents were not present or many medications were included in a single consent rather than separately.

32. HRC-related documentation was not provided and/or could not be located while onsite for six individuals.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 11/11	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

4	The goals/objectives were based upon the individual's assessments.	56% 5/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
1. Of the 14 individuals reviewed by both Monitoring Teams, all but three had PBSPs (seven of the individuals reviewed by the behavioral health monitoring team, two of the individuals from the physical health monitoring team, and the two individuals reviewed by both teams). While the Monitoring Team rated these as meeting criterion, behavioral health services staff are advised to conduct further assessment to determine whether an FBA should be completed (to determine whether a PBSP would be appropriate) for Individual #23 who had a Behavior Protocol and for Individual #261 who reportedly bit her finger.

2-3. All individuals with a PBSP had measurable goals for behavior change.

4. For five individuals, the behaviors identified in the PBSP were based upon the individual's FBA. The exceptions were Individual #441 (disruptive behavior was in the FBA, but not the PBSP), Individual #318 (agitation was included in the PBSP, but not the FBA), Individual #98 (the replacement behavior in the PBSP did not match the hypothesized function identified in the assessment), and Individual #549 (the replacement behavior included in the PBSP did not address both hypothesized functions identified in the assessment).

5. Through review of raw data sheets, examination of data in individual notebooks at the time of the visit, and observation of undocumented problem behaviors, it was determined that data were not reliable for any of the individuals.

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
10	The individual has a current, and complete annual behavioral health update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	44% 4/9	1/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	1/1
12	The functional assessment is complete.	22% 2/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1

Comments:
10. The behavioral health assessments included information cut and pasted from the individual's IRRF. This was repetitive and made the report unnecessarily long. Missing from all reports was a review of the individual's overall physical health and well being, including a summary of any important events from the previous year. The date of completion of the ICAP was missing for Individual #441 and Individual #318. Information regarding living options goals was missing from the behavioral health assessment developed for

Individual #98. Another individual was referenced in the strengths/preferences and tentative goal sections of the behavioral health assessment completed for Individual #549.

11. FBAs were often outdated or included information that was outdated. For example, Individual #303 and Individual #318 had FBAs that were completed in 2014. Individual #303's PBSP indicated that an FBA had been completed in May 2015. When this was requested, the facility provided a behavioral health assessment from January 2015. Although the FBA reports for Individual #525 and Individual #98 were current, the indirect assessments that were reviewed as part of that document were completed between 2011 and 2014.

12. Although descriptive or direct assessments were included, these were limited in number, did not occur across multiple environments, and often described observations during which problem behavior did not occur.

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	56% 5/9	1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1
14	The PBSP was current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
14-15. All of the individuals had a current PBSP. These included operational definitions of targeted problem behaviors and replacement behaviors, consequent strategies for reducing problem behaviors, description of training of replacement behaviors, and data collection procedures.

Areas in need of improvement included the use of positive reinforcement and enhanced opportunities to practice replacement behaviors. Staff are also advised to carefully identify the period of time during which baseline or comparative data were collected, and to clarify expected treatment outcomes (e.g., clarify whether the identified goal is the total number of occurrences of the problem behavior over a six-month period, or is the monthly number of occurrences of the problem behavior over six consecutive months).

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
24	If the IDT determined that the individual needs counseling/	100%	1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

	psychotherapy, he or she is receiving service.	2/2									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 2/2	1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments:
24. Two individuals (Individual #482, Individual #301) were scheduled to attend counseling. A third individual (Individual #98) had been referred for a counseling evaluation, but this was delayed until he could return to his home environment from the infirmary.

25. Treatment plans were complete and progress notes were evident. When Individual #482 refused to attend counseling, changes were made in her plan to first establish rapport with the counselor. The facility is advised to consider community-based counseling services when an individual displays repeated refusal to participate in facility-based counseling.

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	56% 5/9	1/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1	1/1
c.	Individual has timely quarterly reviews for the three quarters in which an annual review has not been completed.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual receives quality AMA.	44% 4/9	0/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
f.	Individual receives quality quarterly medical reviews.	33% 3/9	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1

Comments: d. It was positive that four of the annual medical assessments reviewed included all of the necessary components.

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

f. A number of individuals reviewed did not have quarterly medical reviews completed in the six months prior to the review. Those individuals that did have a recent quarterly medical review available for review had reviews that included the content required by the State Office template.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #7 – aspiration, and gastrointestinal problems; Individual #23 – gastrointestinal problems, and weight; Individual #69 – fluid imbalance, and weight; Individual #347 – constipation/bowel obstruction, and osteoporosis; Individual #466 – respiratory compromise, and gastrointestinal problems; Individual #525 – seizures, and falls; Individual #261 – aspiration, and urinary tract infections (UTIs); Individual #98 – fractures, and seizures; and Individual #150 – weight, and falls]. Overall, the ISPs/IHCPs reviewed did not sufficiently identify the medical care necessary to address the individual's chronic care or at-risk conditions.										

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individual receives timely dental examination and summary:										

	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A	N/R	N/R		N/R					
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	67% 4/6			1/1		1/1	0/1	1/1	1/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 6/6			1/1		1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	22% 2/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/6			0/1		0/1	0/1	0/1	0/1	0/1

Comments: Because Individual #7, Individual #23, and Individual #347 were part of the outcome sample, and were at low risk for dental, some indicators were not rated for them (i.e., the "deeper review" indicators).

a. It was positive that for the individuals reviewed, dental examinations were completed no later than 10 working days prior to the ISP meeting.

b. It was positive that the dental exams of two individuals the Monitoring Team reviewed contained all of the necessary components. It should be noted that both of these individuals were edentulous. For the remaining individuals reviewed, the problems with their dental exams varied, but some of the issues noted were with, as applicable, the identification of caries risk, the identification of periodontal risk, and, in a couple of cases, the description of the individual's cooperation, and/or an oral hygiene rating score.

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

- The number of teeth present/missing;
- Effectiveness of pre-treatment sedation;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations;
- Treatment plan, including the recall frequency; and
- A description of the treatment provided.

Moving forward the Facility should focus on ensuring dental summaries include the following, as applicable, and that the information provided is accurate/complete:

- Recommendations related to the need for desensitization or other plan;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health; and
- Provision of oral hygiene instructions to staff and the individual.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	78% 7/9	0/1	1/1	1/1	1/1	1/1	0/1	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.	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/13	0/2	0/1	N/A	0/1	0/2	0/2	0/1	0/2	0/2

Comments: b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #7 – constipation/bowel obstruction, and polypharmacy/side effects; Individual #23 – respiratory compromise, and UTIs; Individual #69 – skin integrity, and fractures; Individual #347 – constipation/bowel obstruction, and fractures; Individual #466 – behavioral health, and falls; Individual #525 – dental, and constipation/bowel obstruction; Individual #261 – UTIs, and constipation/bowel obstruction; Individual #98 – falls, and cardiac disease; and Individual #150 – constipation/bowel obstruction, and falls).

This indicator was not applicable to Individual #525's dental risk, because at the time of the annual nursing comprehensive assessment, his dental risk rating was low. It was increased to medium at the annual ISP meeting. For the remaining risks reviewed, the annual comprehensive nursing assessments did not contain reviews of them that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. Nursing assessments were not completed in accordance with nursing protocols or current standards of practice for individuals' changes of status.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	6% 1/18	1/2	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.	33% 6/18	2/2	2/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.										
			Individuals:							
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150

a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	0% 0/6	0/1	0/1	0/1	N/A	0/1	0/1	N/A	0/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	17% 1/6	0/1	1/1	0/1		0/1	0/1		0/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/6	0/1	0/1	0/1		0/1	0/1		0/1	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	33% 2/6	0/1	1/1	0/1		0/1	1/1		0/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	25% 1/4	0/1	N/A	0/1		N/A	1/1		0/1	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	33% 2/6	0/1	1/1	0/1		0/1	1/1		0/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/2	0/1	N/A	N/A		N/A	N/A		0/1	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	33% 2/6	1/1	1/1	0/1		0/1	0/1		0/1	

Comments: a. through d., f., and g. For the six individuals that should have been referred to the PNMT:

- The PNMT did not conduct a review in response to Individual #7's pneumonia on 8/7/15, but Individual #7 was referred post fracture on 8/25/15. Due to his high risk of aspiration and previous history of respiratory issues, the diagnosed pneumonia should have triggered the PNMT to conduct at least a review. For the fracture, the assessment process extended beyond 30 days with no justification for the delay.
- Once Individual #23 was referred, the PNMT acted timely in initiating the review/assessment. However, the PNMT did not complete the assessment until 6/6/15, which was beyond 45 days of the referral date of 4/10/15.
- The PNMT did not review Individual #69's aspiration pneumonia event that occurred in January 2015, or the pneumonia event that occurred in March 2015. In addition, he had a 19-pound weight loss from February through March 2015, but the IDT did not refer him to the PNMT until he had lost 34 pounds (criteria is five pounds in a month). As a result, he did not have a timely comprehensive assessment. Once he was referred, the PNMT conducted a comprehensive assessment within 30 days.

- Individual #466 experienced an overall decline in functioning, particularly related to meals and safety of intake, but he was not referred to the PNMT. Individual #466 died on 9/9/15, with causes of death listed as septic shock, aspiration pneumonia, dysphagia, and Down syndrome. In its comments to the draft report, the State indicated that end-of-life decisions for Individual #466 included no PNMT involvement. However, the current documentation for Individual #466 did not clearly document such decisions and/or the justification for them, which would be essential to ensure continuity of care (e.g., should staffing change). Without such documentation, the Monitoring Team's original findings stand.
- Individual #525 lost 17.5 pounds over the months of March to May 2015. Between March and April, he lost 6.5 pounds, and between April and May, he lost 11.5 pounds. Criterion for referral was greater than five pounds in a month. The IDT did not refer him to the PNMT until September 18, 2015, with the PNMT review not initiated until 9/29/15. The PNMT Assessment was not completed until 11/13/15, which was beyond the 30-day mark with no justification for extending it to the 45-day mark.
- For Individual #98, the PNMT did not complete the assessment for his fracture until 9/11/15, when the consult was initiated on 7/7/15. The PNMT also did not conduct a review of an aspiration pneumonia event that occurred in September 2014. In its comments on the draft report, the State indicated: "In reference to the aspiration event of September 2014, PNMT did review this as evidenced by PNMT minutes 9/29/14 that were not requested by monitor." The Monitoring Team reviewed the PNMT evaluation, which was dated 9/10/15. According to the section related to history, there was no evidence of previous PNMT review. The State also indicated; "This singular event did not meet PNMT referral criteria of 2 or more aspiration pneumonia episodes and therefore did not demonstrate a lack of urgency in response to the changes in status…" As the audit tool indicates, the PNMT should conduct a review of any individual that experiences an instance of aspiration pneumonia. This pattern showed a lack of urgency in response to the changes in status Individual #98 experienced.

e. For Individual #7, the PNMT did not discuss the PNMT RN hospital review results after the 8/20/15 pneumonia, and even when the PNMT discussed the results from RN review after the 8/25/15 fracture, this discussion did not include the pneumonia.

Similarly, the PNMT did not discuss Individual #69's January 2015 pneumonia event. In its comments to the draft report, the State indicated that: "PNMT minutes from 2/5/15 (TX-AB-1511.II.72.c, p.5) note that 'post hospital for right pneumonia, pleural effusion, ileus and seizure disorder; current plan is appropriate and PNMT not currently warranted.'" This did not constitute appropriate review or discussion of the event, because it lacked evidence that the PNMT conducted a review of the individual's supports and investigation into root cause.

The RN post-hospital review for Individual #98 included information about aspiration, a seizure, and a fracture, but the PNMT did not discuss the pneumonia.

h. Although they were not completed timely, it was positive that the PNMT conducted thorough Comprehensive PNMT Assessments for Individual #7, and Individual #23. The PNMT assessment for Individual #7 focused on the potential cause of the fracture and factors related to positioning to help mitigate future occurrence and provide a safe environment. For Individual #23, the PNMT conducted a good review of the individual's history, medications, and potential social issues that could have impacted the weight loss issue. As discussed above, the PNMT should have conducted an assessment for Individual #466, but did not. For the remaining individuals, problems with PNMT assessments varied, but in one or more the following components were missing or incomplete:

- Assessment of current physical status;
- Recommendations, including rationale, for physical and nutritional interventions; and
- Recommendations for measurable goals/objectives, as well as indicators and thresholds.

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

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
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).	67% 12/18	1/2	1/2	1/2	2/2	2/2	1/2	2/2	0/2	2/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	17% 3/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	2/2
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.	6% 1/18	0/2	0/2	0/2	1/2	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.	39% 7/18	1/2	0/2	0/2	1/2	0/2	1/2	2/2	1/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	25% 3/12	0/1	0/1	0/1	0/1	2/2	0/2	0/1	0/2	1/1
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included goals/objectives related to: aspiration, and fractures for Individual #7; aspiration, and weight for Individual #23; aspiration, and weight for Individual #69; choking, and weight for Individual #347; aspiration, and choking for Individual #466; choking, and weight for Individual #525; aspiration, and falls for Individual #261; fractures, and aspiration for Individual #98; and choking, and falls for Individual #150.

a. The ISPs/IHCPs that did not sufficiently address the individual's identified PNM needs as presented in the PNMT assessment/review or PNMP were those for fractures for Individual #7; weight for Individual #23; weight for Individual #69; weight for Individual #525; and fractures, and aspiration for Individual #98.

b. ISPs/IHCPs reviewed often did not include preventative measures to minimize the individual's condition of risk. Those that did were those for weight for Individual #347; and choking, and falls for Individual #150.

c. All individuals reviewed had PNMPs. All of the PNMPs included some, but not all of the necessary components to meet the individuals' needs. None of the PNMPs included all of the necessary photographs. Some of the other problems with some of the PNMPs included that they had not been updated to reflect the individual's current needs/supports, individualized triggers were not included, missing adaptive equipment, and incomplete or out-of-date information about the individual's communication needs and/or equipment.

d. The IHCP that identified the actions steps necessary to meet the identified objective was the one for weight for Individual #347.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for aspiration for Individual #7; choking for Individual #347; choking for Individual #525; aspiration, and falls for Individual #261; aspiration for Individual #98; and choking for Individual #150.

f. IHCPs reviewed defined individualized triggers, as appropriate, and actions to take when they occur were those for aspiration, and choking for Individual #466; and choking for Individual #150.

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

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
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% 3/3	1/1	N/A	1/1				1/1		
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	100% 1/1	N/A		1/1				N/A		
Comments: None.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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.	0% 0/3	N/A	N/A	0/1	N/A	0/1	N/A	N/A	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/6	0/1	0/1	N/A	0/1	N/A	0/1	0/1	N/A	0/1

Comments: a. and b. Based on the records reviewed, a number of individuals did not have OT/PT assessments and updates completed in a timely manner and/or that met their needs. In addition, some individuals experienced changes in status that necessitated an OT/PT assessment, but such assessments were not completed. The following provide some examples of the concerns noted:

- Many individuals reviewed (e.g., Individual #7, Individual #23, Individual #69, Individual #347, Individual #466, Individual #525, and Individual #261) had addendums completed, but these documents did not qualify as updates, because they lacked the detail and level of review needed.
- On 1/13/15, a Head of Bed Evaluation was requested for Individual #23, but there was no evidence that the OT/PT completed it.
- For Individual #69:
  - As noted in PNMT minutes dated 9/11/15, Individual #69 was supposed to have an assessment using the Frazier Free Water Protocol, but did not. In its comments on the draft report, the State referred to OT/PT addenda. However, the assessment completed as part of the 9/25/15 and 9/17/15 addenda did not reflect assessment of the Frazier Free Water Protocol that takes into account oral cleanliness and tolerance of plan free water. Instead, they reflected assessment of overall diet tolerance.
  - On 6/22/15, a low vision assessment was requested, but it was not completed until 8/4/15.

- In addition due to a significant changes in status (i.e., possible cardiovascular accident in November 2014), a full assessment was warranted, but was not completed.
- The Head of Bed Evaluation for Individual #69 was not based on any objective data. In the Head of Bed Evaluation, it stated that a wedge might need to be provided if Individual #69 sleeps in his bed. It was unclear why this was not assessed and the support provided. In its response to the draft report, the State indicated: "HOB to 30° recommendation for individual #69 was based on evidenced based research that 30° is the standard to reduce the risk of aspiration s/p G-tube placement. A wedge was not required at the infirmary as he was using a hospital bed, but "might need to be provided" at home because he did not have a hospital bed at home. The PT was being proactive in PNM supports based on his history of preference for lying flat at home." Thirty degrees is standard for someone with normal musculature and who is not having breakthrough issues. When an individual is having issues with GERD breakthrough and/or aspiration, such as was the case for Individual #69, then further assessment is warranted.

- For Individual #347, there was no evidence of an eating evaluation that focused on oral motor capabilities since 2004. The IDT discussed the need for PT therapy, and the PT responded with the following: "[They] could but it would be awhile and would be completed in the next 6 months." In its response to the draft report, the State indicated: "Individual #347 had eating evaluation addenda dated 5/30/13 and 11/25/14 (TX-AB-1511.II.93.d, pgs. 4 and 5) that addressed any changes needed for dining. The OT/PT Annual Program Review dated 5/28/15 (TX-AB-1511.II.93.d, p. 3) notes that this individual also had a full OT/PT evaluation that included oral motor information. It also documents that all individualized assistive equipment for eating remained appropriate." None of the assessments provided or document request numbers submitted include what would be considered a functional oral motor assessment.
- For Individual #466, there was no evidence of a PT assessment in response to significant changes over the last two years, including but not limited to decreased mobility, increased falls, decreased balance, and decreased ability to dress and feed himself. An ISPA, dated 8/31/15, referenced an eating evaluation, but no evidence of one was provided. Similarly, a Head of Bed Evaluation was requested, but no evidence of an evaluation was found, with only a statement that 30 degrees is better for GERD management than greater than 30 degrees. Individual #466 died on 9/9/15, with causes of death listed as septic shock, aspiration pneumonia, dysphagia, and Down syndrome.
- Beginning in April 2015, Individual #525 had an increase in pain and decrease in ambulation, but there was no evidence of a PT consult to address his hip pain. No review was found of his walking program to ensure appropriateness and safety of the program.
- Individual #261 had a review completed on 8/10/15 for an ISP dated 9/3/15. The review noted a need for a wheelchair assessment, as well as an eating evaluation. However, it gave the timeframes for completion as one to three months for the wheelchair, and six to 12 months for the eating evaluation. These timeframes were not sufficient to meet the needs of the individual, given that it was noted that Individual #261 was not sitting properly in the wheelchair.
- For Individual #98, an updated full evaluation was indicated due to the significant decline in adaptive living skills, as noted in multiple assessments (PNMT and OT/PT annual review), but was not completed.

d. and e. Individual #69, Individual #466, and Individual #98 should have had comprehensive assessments, but did not. As noted above, for the remaining individuals, the addendums completed did not qualify as updates, because they did not include thorough review of the following elements:

- 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;

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	20% 2/10	0/1	0/1	1/2	0/1	0/1	0/1	0/1	0/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	60% 3/5	1/1	0/1	1/1	0/1	N/A	N/A	N/A	1/1	N/A

Comments: a. Given that individuals' OT/PT status had not been fully assessed/reviewed or updated since 2013, the Monitoring Team could not determine if the statuses described in individuals' ISPs were an accurate reflection of their current statuses.

b. It was good to see that IDTs had discussed and, as appropriate, updated individuals' PNMPs as part of the annual ISP process.

d. The following describe the actions IDTs took or did not take:

- For Individual #7, meetings were held on 8/25/15 and 9/2/15 to determine safe transfers and positioning post fracture.
- Individual #23's IDT did not meet to discuss various consult results (e.g., possible modification of palm protectors).
- On 9/17/15, Individual #69's IDT discussed the need for active OT treatment.
- No ISPA was held to discuss Individual #347's walking program.
- On 9/23/15, Individual #98's IDT met to discuss initiation of PT.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	33% 3/9	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/2	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	14% 1/7	0/1	0/1	N/A	0/1	N/A	1/1	0/1	0/1	0/1

Comments: a. and b. The following describe some of the concerns noted:

- In September 2015, Individual #69's status changed from being able to verbally communicate to being a non-verbal communicator. Such a significant change of status should have triggered a full assessment, but the SLP did not complete one.
- Individual #347's last full evaluation was completed in 2011. Despite the fact that Individual #347 had environmental controls until they were discontinued in 2013, she did not have communication assessment updates, or further assessment to consider other communication possibilities. Additionally, no consult appeared to have been completed in response to the QIDP's request in July 2015 to have the SLP look at the addition of an EC device to Individual #347's wheelchair.
- For Individual #466, a SLP last completed a full evaluation in August 2013. Due to his decreasing communication and cognition, a full comprehensive assessment was warranted as his status varied significantly from one year to the next.
- Despite the fact that Individual #261 has an adaptive switch, the last communication update was completed in 2012, with an AAC addendum in October 2014.
- Although Individual #98 had a communication SAP, the SLP provided no review or update prior to the most recent ISP meeting. The last evaluation was completed in 2009.
- Individual #150 had communication supports in the form of a SAP in 2015, and use of communication boards and books from 2012 to 2015. However, the SLP provided no updates since 2012.
- The addendums for Individual #7 and Individual #23 only addressed AAC, but did not provide an overall review or update on services. To just state that the previous assessment is appropriate does not constitute a review or update on services. The reviews lacked evidence of data collection to substantiate findings.

- For Individual #525, the 2013 Comprehensive Communication Assessment indicated that an update would be provided annually, but there was no evidence the SLP completed an update in 2014. However, an update was completed on 1/15/15 in preparation for his ISP meeting on 1/27/15.

d. and e. It was positive to see that Individual #525 had an update, dated 1/15/15, that included all of the necessary components. However, as noted above, SLPs had not completed comprehensive assessments or updates to address the needs of most individuals reviewed. Moving forward, the Facility should ensure communication assessments and updates address, and/or include updates, as appropriate, regarding:

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

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

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
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.	33% 3/9	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	13% 1/8	0/1	0/1	1/1	0/1	N/A	0/1	0/1	0/1	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: b. It was positive that during ISP meetings, individuals' IDTs discussed changes to their Communication Dictionaries, and these changes were then reflected in the communication sections of the PNMPs.											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	91% 21/23	1/3	3/3	2/2	3/3	3/3	3/3	3/3	2/2	1/1
3	The individual's SAPs were based on assessment results.	56% 13/23	0/3	1/3	0/2	2/3	3/3	3/3	3/3	0/2	1/1
4	SAPs are practical, functional, and meaningful.	56% 13/23	0/3	2/3	1/2	1/3	2/3	3/3	3/3	0/2	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/23	0/3	0/3	0/2	0/3	0/3	0/3	0/3	0/2	0/1

Comments:

1. All individuals had at least one SAP.

2. The Monitoring Team chooses three current SAPs for each individual for review. Individual #441 and Individual #98 had two SAPs and Individual #549 had one SAP, for a total of 23 SAPs. In two SAPs (shopping and schedule) developed for Individual #482, there was a lack of correspondence between the objective and the steps described in the SAP.

4. SAPs were not always functional or meaningful. For example, Individual #482 had a healthy food choice SAP that required her to comment on information provided on food package labels. This was clearly not teaching her to make healthy choices because immediately after commenting on the number of calories in a package of Ramen noodles, she stated that she was going to order a

number two meal at McDonalds. She explained that this consisted of two hamburgers, a large order of French fries, and a soda. She added that she was going to also get a side order of chicken nuggets. For others (e.g., Individual #482 schedule, Individual #301 card writing), repeated refusal to participate suggested that this was not meaningful to the individual. Individual #98 was to use his communication book to indicate which horses he wanted to talk about, resulting in a very restricted use of what could be a functional augmentative system.

5. The facility had no system in place for assessing the reliability of data.

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
10	The individual has a current FSA, PSI, and vocational assessment.	56% 4/9	1/1	0/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	33% 3/9	0/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	33% 3/9	0/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1

Comments:

10. One or more of the required assessments were either missing or not current for four individuals (Individual #441, Individual #301, Individual #98, Individual #549).

11. For four individuals (Individual #482, Individual #525, Individual #98, Individual #549), one assessment was completed after the ISP meeting. For two others, the FSA was completed two days before the ISP (Individual #303), or on the same day as the ISP (Individual #301).

12. Recommendations for SAP development were not provided in most FSAs or vocational assessments.

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

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
			Individuals:								
#	Indicator	Overall Score	482								
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	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 1/1	1/1								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the 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 maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	100% 1/1	1/1								

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

Comments:

18-19. Only Individual #482 experienced restraint more than three times in a rolling 30-day period between 4/1/15 and 9/30/15. During this time, the IDT met on 4/6/15 within 10 days of multiple restraints. It should be noted that when physical and chemical restraint were applied simultaneously, this was considered one restraint with regard to this review.

20. The ISPA minutes reflected discussion of potential role of adaptive skills, and biological, medical, and psychosocial issues. Medications had been reviewed and adjusted, and staff continued to receive training in how best to interact with the individual. Although it was noted that "overall active treatment was not meeting (her needs)," there were no specific plans identified to increase her active treatment on campus. Further, although vocational services agreed to increase her scheduled work time, a vocational assessment was not completed until 10/19/15.

27. One component of her plan was the use of a Respite Home. While it was evident through discussion with the Director of Behavioral Health Services that the purpose of this home was to ensure the safety of the individual and those with whom she lived, strict oversight is advised. Staff should keep a running record of the time the individual spends at the respite home, including the hours when she is restricted to the home. Documentation should also be maintained regarding the individual's participation in work, counseling, and other habilitation activities. A summary of all action taken to enhance the individual's program while at the Respite Home should be included in her record.

28-29. Treatment integrity was assessed weekly. In addition, the External Peer Review Committee reviewed and discussed this individual at the scheduled monthly meeting.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
1	If not receiving psychiatric services, a Reiss was conducted.	100% 3/3	N/A	N/A	1/1	N/A	N/A	N/A	N/A	1/1	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
1. For the 16 individuals reviewed by both Monitoring Teams, all but three of the individuals were receiving psychiatric services. Individual #441 and Individual #98 had Reiss scales completed in 2010 that yielded scores below the cut-off for referral for psychiatric evaluation. Each Reiss report was accompanied by a one to two page note that provided an overview of the individual's demographic information and a brief historical context.

2-3. Individual #23 was the third individual who was not receiving psychiatric services. He was one of the individuals reviewed by the medical Monitoring Team and, therefore, is not included in the above chart. He had not been receiving psychiatric services since early 2012. A change of status in mid-2015 led to the conduct of a new Reiss. His score was above the cut off and he was referred to psychiatry for evaluation. Psychiatry made some recommendation for his supports, but determined that a full evaluation was not required. Because protective devices were used, the Monitoring Team recommended that a functional assessment and PBSP be developed for him.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
8	The individual is making progress and/or maintaining stability.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/7	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1

11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1

Comments:
8-9. Without measurable goals and objectives as per the criterion and comments under psychiatry indicators 4 to 7 in this report, progress could not be determined. Thus, the first two indicators were scored at 0%. In its response to the draft report, the State pointed to progress described in quarterly reviews for seven of the individuals and in the CPE for the eighth individual. This was good to see, however, once individualized goals exist, these two indicators are then more likely to meet criterion.

10-11. Despite the absence of measurable goals it was apparent that when the facility's own observations and data showed that individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and were implemented.

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	75% 6/8	1/1	0/1	0/1	1/1	1/1	1/1	1/1	N/A	1/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1

Comments:
23. Criterion was met for six individuals. For Individual #303, the functional assessment alluded to the psychiatric diagnosis and the symptoms, but it provided only general comments about the impact of these diagnoses on his behavioral presentation and these were not factored into the development of the interventions for his behavioral treatment. For Individual #441, the September 2015 functional assessment and PBSP did not include any reference or impact of the depressive disorder diagnosis that was in the August 2015 CPE.

24. The psychiatry department regularly engaged the behavioral health services department during the quarterly reviews and for interim clinics and consultations. There was no evidence that psychiatry participated in its development of the PBSP for the individuals. Evidence of psychiatry participation in the development of the PBSP is required for criterion to be met for this indicator.

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549

25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
26	Frequency was at least annual.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
Comments: 25-27. Individual #549's case was the only one of the individuals reviewed by the Monitoring Team for which there was true dual use. There was good documentation of collaboration.											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
33	Quarterly reviews were completed quarterly.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
34	Quarterly reviews contained required content.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 3/3	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A	1/1
Comments: 33-34. Quarterlies were done timely and were thoroughly and completely documented. 35. The Monitoring Team observed psychiatry clinic for three individuals (Individual #441, Individual #525, Individual #549). All three met the criteria for this indicator.											

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	75% 6/8	1/1	1/1	1/1	0/1	0/1	1/1	1/1	N/A	1/1
Comments: 36. In general, these assessments were performed in a timely manner and reviewed by the psychiatrist within 15 days. The exceptions were the DISCUS completion and also review by psychiatrists across the review period for Individual #318 and Individual #301.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 7/7	1/1	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 7/7	1/1	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7	1/1	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1
Comments: 37-39. These indicators applied to seven of the individuals. There was documentation evidence that the psychiatrists were available to perform consultation clinics in between the scheduled clinics when required.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 40-43. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment. The facility did not use PEMA.											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549

44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 4/4	N/A	1/1	N/A	N/A	1/1	1/1	N/A	N/A	1/1
45	There is a tapering plan, or rationale for why not.	100% 4/4	N/A	1/1	N/A	N/A	1/1	1/1	N/A	N/A	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 4/4	N/A	1/1	N/A	N/A	1/1	1/1	N/A	N/A	1/1

Comments:
44-46. These indicators applied to four of the individuals. The psychiatry staff and the facility continued to do a good job in managing polypharmacy. Moreover, the facility had a number of new admissions from the community who were receiving large numbers of medication. These individuals were readily incorporated into the polypharmacy management program, often with good success.

Psychology/behavioral health

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	Activity and/or revisions to treatment were implemented.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
6. Graphs included in the behavioral health monthly progress notes reflected a lack of progress for Individual #482, Individual #303, Individual #441, Individual #301, and Individual #525. However, progress cannot be assessed for any of the individuals due to the lack of reliable data.

8-9. It was evident that Individual #482's PBSP had been revised multiple times, often in response to feedback provided by the External Peer Review Committee.

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	13% 1/8	1/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
17	There was a PBSP summary for float staff.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 16. The facility provided evidence of training provided to staff assigned to the homes of eight of the individuals. The exception was Individual #98 who had been hospitalized or in the infirmary for an extended period of time prior to the visit. Based upon the spreadsheets provided, there was evidence that all of the staff assigned to Individual #301's home had been trained. There was no evidence provided regarding training provided to day or work site staff for any of the individuals. 18. The facility and behavioral health services department are commended for the efforts that staff have made to become BCBAs.											

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
19	The individual's progress note comments on the progress of the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	11% 1/9	1/1	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.	100% 3/3	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A	1/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	75% 3/4	1/1	N/A	1/1	0/1	1/1	N/A	N/A	N/A	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%	This is a facility indicator; it was scored yes.								
Comments:											

19. All the individuals had Behavioral Health Monthly Progress Reports in which progress on the PBSP was reviewed.

20. With the exception of Individual #482, all data were presented in monthly intervals. This negatively impacted one's ability to assess the effects of revisions to the PBSP as well as changes in the individual's health, medication (including dosing), environment, and other variables. In its response to the draft report, the State argued that the data for the other eight individuals did not require smaller intervals. However, the Monitoring Team's review of the behavioral health progress notes for these eight individuals noted changes to their health, changes in medication, changes in residence, changes in staffing including level of supervision, and/or changes in the PBSP during the time period. Each of these events can impact behavior occurrences. At a minimum, weekly presentation of data would allow for a more careful analysis of response to treatment.

21. The onsite psychiatric clinic for all three individuals included the review of data collected on all targeted behaviors addressed in the PBSP. Behavioral health services staff presented the most recent monthly progress note, which included graphic display of data.

22. For three of four individuals, there was evidence of changes to an individual's PBSP following case presentation at meetings of either the Internal or External Peer Review Committees. The exception was Individual #318. His PBSP did not address the hypothesized function of escape nor did it clearly describe the punch card system, both of which were identified by the Internal Peer Review Committee on 5/27/15.

23. The Internal Peer Review Committee met three to five times each month between 4/1/15 and 9/30/15. The External Peer Review Committee met monthly to confer on identified individuals, including Individual #482.

Outcome 8 – Data are collected correctly and reliably.

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	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).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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:
28-29. The facility is commended for having measures of data timeliness, IOA, and treatment integrity (#28), and for identifying

expected frequency of IOA and treatment integrity measures in the individual's PBSP (though not yet for data timeliness, #29).

30. Goals for frequency and level were not yet achieved. Retraining in the PBSP is expected if staff score below 90% on measures of treatment integrity.

Medical

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

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
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.	56% 10/18	2/2	2/2	1/2	2/2	0/2	0/2	0/2	1/2	2/2
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 #7 – aspiration, and gastrointestinal problems; Individual #23 – gastrointestinal problems, and weight; Individual #69 – fluid imbalance, and weight; Individual #347 – constipation/bowel obstruction, and osteoporosis; Individual #466 – respiratory compromise, and gastrointestinal problems; Individual #525 – seizures, and falls; Individual #261 – aspiration, and UTIs; Individual #98 – fractures, and seizures; and Individual #150 – weight, and falls). From a medical perspective, none of the goals/objectives were clinically relevant and achievable. The ones that were measurable, but not clinically relevant/achievable were the ones for Individual #7 – aspiration, and gastrointestinal problems; Individual #23 – gastrointestinal problems, and weight; Individual #69 – weight; Individual #347 – constipation/bowel obstruction, and osteoporosis; Individual #98 – fractures; and Individual #150 – weight, and falls.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
g.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 5/5	1/1	1/1	N/A	1/1	1/1	N/A	N/A	1/1	N/A
	iii. Breast cancer screening	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	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	1/1	1/1	1/1	1/1	N/A	1/1	0/1	N/A
	vii. Cervical cancer screening	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
h.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	Not rated									

Comments: g. For Individual #466, according to the AMA, dated 7/10/15, a varicella test for immunity was ordered, but the results were not found in the lab section of the submitted documents.

On 6/24/15, Individual #98 sustained a hip fracture. During the hospitalization requiring surgery, there was a recommendation for an outpatient evaluation for osteoporosis. At the time of the Monitoring Team's onsite review, approximately five months post-fracture, a DEXA scan had not been completed.

h. This indicator was not rated during this review, but will be during upcoming reviews.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
			Individuals:								
#	Indicator	Overall	7	23	69	347	466	525	261	98	150

		Score									
a.	Individual with DNR that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: None.											

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
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.	53% 9/17	1/2	2/2	1/2	2/2	2/2	0/2	1/2	0/2	0/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	100% 12/12	1/1	2/2	2/2	2/2	1/1	1/1	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.	86% 6/7	2/2	N/A	2/2	N/A	2/2	N/A	N/A	0/1	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% 1/1	1/1		N/A		N/A			N/A	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	86% 6/7	2/2		2/2		1/2			1/1	
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 7/7	2/2		2/2		2/2			1/1	
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	33% 1/3	1/1		0/1		N/A			0/1	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 6/6	2/2		2/2		1/1			1/1	

Comments: a. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 17 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #7 (red eye on 9/10/15, and ceruminosis on 9/5/15), Individual #23 (coccygeal skin breakdown on 5/13/15, and 4/17/15), Individual #69 (watery stools on 9/22/15, and vomiting on 7/24/15), Individual #347 (fracture of the toe on 5/18/15, and breast enlargement on 5/16/15), Individual #466 (left foot infection on 8/27/15, and neck edema on 8/19/15), Individual #525 (fractured finger on 7/19/15, and head banging on 7/1/15), Individual #261 (swollen right hand on 9/3/15, and reactive airway disease on 8/1/15), Individual #98 (constipation on 9/20/15, and insomnia on 8/31/15), and Individual #150 (fall on 6/25/15, and wrist pain on 7/2/15). For the following acute issues, medical providers at Abilene SSLC followed accepted clinical practice in assessing them: Individual #7 (ceruminosis on 9/5/15), Individual #23 (coccygeal skin breakdown on 5/13/15, and 4/17/15), Individual #69 (vomiting on 7/24/15), Individual #347 (fracture of the toe on 5/18/15, and breast enlargement on 5/16/15), Individual #466 (left foot infection on 8/27/15, and neck edema on 8/19/15), and Individual #261 (reactive airway disease on 8/1/15).

b. For all applicable acute illnesses reviewed that occurred at the Facility, documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized, which was good to see.

c. The Monitoring Team reviewed seven acute illnesses requiring Infirmary admission, hospital admission, or ED visit, including the following with dates of occurrence: Individual #7 (ED visit for abdominal distension and labored respirations on 8/27/15, and hospitalization for fracture of the femur on 8/21/15), Individual #69 (hospitalization for ataxia on 8/16/15, and ED visit for seizures on 6/14/15), Individual #466 (hospitalization for aspiration pneumonia on 9/7/15, and ED visit for fall with contusion to the head on 6/25/15), and Individual #98 (hospitalization on 6/24/15 after unwitnessed fall).

d. For Individual #7's fractured femur on 8/21/15, it was positive that a quality assessment was documented in the IPN.

e. For the acute illnesses reviewed, it was positive the individuals generally received timely treatment at the SSLC. The exception was Individual #466 (ED visit for fall with contusion to the head on 6/25/15) for whom no first aid was documented.

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

g. With regard to meeting to develop post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness:

- Individual #7's team met after his return from the hospital with a fractured femur. Although the cause was unknown, the IDT met with the PNMT to discuss his change of status, and a plan for moving forward, including monitoring to ensure the PNMP was followed.
- On 9/7/15, Individual #466 was hospitalized for aspiration pneumonia. On 9/9/15, he died in the hospital with causes of death listed as septic shock, aspiration pneumonia, dysphagia, and Down syndrome. Therefore, this indicator was not applicable.
- For Individual #98, the ED record stated: "found on floor at state school [SSLC]. EMS [Emergency Medical Staff] states right leg was bent at knee and internally rotated but patient fought en route and lifted self up and now it is externally rotated." The hospitalist service consultation stated: "experienced an unwitnessed fall earlier this afternoon. Employee that is currently at the bedside does not know much of the patient's hx [history] and does not know the circumstances regarding his recent fall… apparently at a function [Activity Center] when he got up to go to the bathroom. He did not return for about 30 minutes and then was found on the floor in a significant amount of pain in the right hip and elbow. It is unknown if he lost any consciousness or had a seizure resulting in his fall." The IDT did not meet until several weeks after his return from the hospital, and although a root cause was discussed (i.e., being pushed by a peer), it is unclear how other possible root causes were ruled out.

h. It was good to see that for the acute illnesses reviewed for which individuals received care at the Infirmary, an ED, or in this hospital, PCPs 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.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	1/1	2/2	2/2

b.	PCP completes review within five business days, or sooner if clinically indicated.	100% 15/15	2/2	2/2	2/2	2/2	2/2	2/2	1/1	2/2	N/A
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	1/1	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	53% 9/17	2/2	0/2	1/2	2/2	1/2	0/2	1/1	0/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #7 for pulmonary on 9/29/15, and neurology on 9/28/15; Individual #23 for cardiology on 7/28/15, and neurology on 6/22/15; Individual #69 for endocrinology on 7/14/15, and neurology on 9/21/15; Individual #347 for orthopedics on 9/16/15, and podiatry on 9/15/15; Individual #466 for nephrology on 7/30/15, and neurology on 7/27/15; Individual #525 for ophthalmology on 6/19/15, and orthopedics of 7/27/15; Individual #261 for ophthalmology on 10/13/15; Individual #98 for orthopedics on 9/16/15, and orthopedics on 8/26/15; and Individual #150 for dermatology on 5/21/15, and dermatology on 6/18/15.

a. and c. It was positive that for the individuals reviewed, PCPs reviewed consultation reports, indicated agreement or disagreement with the recommendations, and wrote corresponding IPNs, as State Office policy requires.

b. For Individual #150, documentation was not sufficient to show when Facility staff received the consultation reports and distributed them to the PCPs. Therefore, this indicator could not be assessed.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show they were ordered (in some instances, orders were not found for all agreed upon recommendations) for the following: Individual #23 for cardiology on 7/28/15 (i.e., a pacemaker check was due in two months, but the PCP ordered it for six months), and neurology on 6/22/15 (i.e., no follow-up clinic appointment ordered); Individual #69 for endocrinology on 7/14/15 (i.e., the individual needed follow-up in two months, but this was not ordered); Individual #466 for nephrology on 7/30/15 (i.e., no order for follow-up); Individual #525 for ophthalmology on 6/19/15 (i.e., no order for follow-up), and orthopedics of 7/27/15 (i.e., no order for follow-up or buddy tape); and Individual #98 for orthopedics on 9/16/15 (i.e., no orders for PT), and orthopedics on 8/26/15 (i.e., no orders for activity, including exercise program).

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations,	33% 6/18	2/2	0/2	1/2	1/2	2/2	0/2	0/2	0/2	0/2

	consistent with current standards of care.										

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #7 – aspiration, and gastrointestinal problems; Individual #23 – gastrointestinal problems, and weight; Individual #69 – fluid imbalance, and weight; Individual #347 – constipation/bowel obstruction, and osteoporosis; Individual #466 – respiratory compromise, and gastrointestinal problems; Individual #525 – seizures, and falls; Individual #261 – aspiration, and UTIs; Individual #98 – fractures, and seizures; and Individual #150 – weight, and falls).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #7 – aspiration, and gastrointestinal problems; Individual #69 – fluid imbalance; Individual #347 – osteoporosis; and Individual #466 – respiratory compromise, and gastrointestinal problems. The following provide a couple of examples of concerns noted regarding medical assessment, tests, and evaluations:

- At the time of his March 2015 ISP meeting, Individual #23 experienced a slow but steady unplanned weight loss of 31 pounds over the course of the year. Although some testing and evaluations had been completed, a thorough review to determine the cause had not occurred (e.g., consideration of medication(s) contributing to anorexia, exacerbation of his gastrointestinal reflux disease, depression, etc.).
- In the last year, Individual #347 used 19 suppositories as compared to the previous year in which she used 12. The IDT discussed the probability that the current supports were not effective due to the increased use of suppositories. Although some action was taken (e.g., a referral to an orthopedist to address knee pain that contributed to decreased mobility), a complete medical assessment/evaluation did not appear to have occurred (e.g., consideration of the need for motility studies, review of medications that might contribute to constipation, etc.).
- Individual #525's IDT sought second opinions regarding treatment for his avascular necrosis of the left hip, which can cause significant pain. Options discussed were a hip replacement, but his behavioral issues reportedly increased the risk of permanent damage, or a Girdlestone procedure, which might provide pain relief, but had the potential to leave him with an abnormal hip (i.e., possibly eliminating his ability to walk). The problem appeared to be stable at times over the last year (i.e., he sometimes was ambulating with help), but then other documentation indicated he appeared to be in pain (e.g., dropping to the floor, refusing to assist with transfers, etc.). Documentation did not show necessary coordination between medical, psychiatric, and behavioral staff, or reliable data collection regarding his pain. As a result, a clear plan had not been implemented to improve his behaviors, review medications that might be causing other discomfort, and/or rule out treatable conditions.
- For Individual #261, it did not appear that the cause for her urinary retention had been evaluated.
- Individual #98 experienced status epilepticus twice within the last year, had been hospitalized for high ammonia levels, which appeared to be caused by the Valproic Acid he was prescribed for seizures, and had an unwitnessed fall and broke his hip (i.e., staff speculated that a peer pushed him, but a seizure had not been ruled out). It was unclear whether or not the medical team considered changing the Valproic Acid to a medication(s) that does not decrease platelets and does not elevate ammonia, which can contribute to further risk of falling. In addition, the treatment plan after his hip fracture was of insufficient intensity, and did not reflect good interdisciplinary coordination.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.	
	Individuals:

#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 13/13	2/2	2/2	2/2	1/1	1/1	2/2	1/1	2/2	N/A
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs (e.g., often this was only to assess the individual when a negative health event occurred and was reported) that were identified for the individuals reviewed generally were implemented.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	24% 9/37	2/6	2/5	1/2	1/4	1/4	0/5	0/3	2/5	0/3
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	Not Rated									
Comments: The Monitoring Team's document request read: "Documentation of the Pharmacy's review of the five most recent new medication orders for the individual." All individuals had one or more new medication order for which no information was submitted related to Pharmacy's review. Although some patient intervention forms were submitted, multiple new medication orders had no evidence of review. The Monitoring Team could not rate indicator "b," because it could not determine how many interventions were needed.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2

b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
	ii. Benzodiazepine use;	0% 0/8	0/1	N/A	0/1	0/2	N/A	0/2	N/A	N/A	0/2
	iii. Medication polypharmacy;	0% 0/6	0/2	N/A	0/2	0/2	N/A	N/A	N/A	N/A	N/A
	iv. New generation antipsychotic use; and	67% 4/6	N/A	N/A	N/A	2/2	N/A	0/2	N/A	N/A	2/2
	v. Anticholinergic burden.	56% 10/18	0/2	0/2	0/2	0/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	89% 16/18	2/2	2/2	2/2	1/2	2/2	2/2	2/2	2/2	1/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 7/7	N/A	N/A	N/A	2/2	1/1	2/2	N/A	N/A	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	78% 7/9	0/1	N/A	1/2	N/A	1/1	1/1	1/1	2/2	1/1

Comments: a. and b. The Monitoring Team requested the last two QDRRs for nine individuals. It was positive that QDRRs had been completed quarterly. However, it was concerning that necessary information and recommendations were missing from many of them.

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

d. Evidence was not found to show that agreed-upon recommendations from the following QDRRs and/or new interventions were implemented: for Individual #7 in response to a patient intervention, dated 8/28/15, the PCP indicated that the individual would be monitored for symptoms of toxicity (i.e., somnolence/respiratory depression), but did not write an order for monitoring; and for Individual #69, a pharmacy note related to a QDRR stated that the PCP would order Vitamin D, but the order was not written, and there was no follow-up until next QDRR.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5	N/A	N/A	0/1	N/A	N/A	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	20% 1/5			1/1			0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/5			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% 0/5			0/1			0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5			0/1			0/1	0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed five individuals with medium or high dental risk ratings. Some goals/objectives focused on a change or maintenance of oral hygiene ratings, which were only completed once or twice a year. Goals/objectives focusing on the causes of the medium or high risk dental rating and/or goals/objectives with more incremental measures would allow IDTs to determine whether or not the individual was progressing, regressing, or maintaining his/her status.

c. through e. Progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these five individuals, as well as the individual in the core sample for whom this indicator was marked N/A (i.e., Individual #466). For Individual #7, Individual #23, and Individual #347, who were at low risk for dental, and who were in the outcome sample, the "deep review" items were not scored, but other items were scored.

Outcome 4 – Individuals maintain optimal oral hygiene.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	If the individual has teeth, individual has prophylactic care at least	50%	1/1	N/A	0/1	N/A	N/A	0/1	1/1	0/1	1/1

	twice a year, or more frequently based on the individual's oral hygiene needs.	3/6									
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	33% 2/6	0/1	N/A	0/1	N/A	N/A	1/1	0/1	1/1	0/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	100% 6/6	1/1	N/A	1/1	N/A	N/A	1/1	1/1	1/1	1/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	Not rated									
e.	If the individual has need for restorative work, it is completed in a timely manner.	N/A									
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									
Comments: a. Individual #23, Individual #347, and Individual #466 were edentulous. d. This indicator was not rated during this review, but will be during the next review.											

Outcome 6 – Individuals receive timely, complete emergency dental care.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: None of the individuals the Monitoring Team responsible for the review of physical health reviewed had dental emergencies within the six months prior to the review.											

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	If individual would benefit from suction tooth brushing, her/his ISP	0%	N/R	N/R	N/A	N/R	0/1	N/A	0/1	N/A	N/A

	includes a measurable plan/strategy for the implementation of suction tooth brushing.	0/2									
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/2					0/1		0/1		
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/1					N/A		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% 0/1					N/A		0/1		
Comments: Because Individual #7, Individual #23, and Individual #347 were part of the outcome samples and were at low risk for dental, some indicators were not rated for them (i.e., the "deeper review" indicators), including these related to suction tooth brushing.											

Outcome 8 – Individuals who need them have dentures.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: For the individuals reviewed with missing teeth, the Dental Department conducted an assessment, and provided clinical justification for not pursuing dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	60% 6/10	1/2	0/1	1/2	N/A	2/2	2/2	N/A	0/1	N/A

b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	78% 7/9	1/2	0/1	1/1		2/2	2/2		1/1	N/A
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	27% 3/11	1/2	0/1	0/2		0/2	1/2		1/1	0/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	60% 3/5	2/2	N/A	1/1		0/1	N/A		0/1	N/A
e.	The individual has an acute care plan that meets his/her needs.	9% 1/11	0/2	0/1	0/2		0/2	1/2		0/1	0/1
f.	The individual's acute care plan is implemented.	9% 1/11	0/1	0/1	0/1		0/1	1/2		0/1	0/1

Comments: The Monitoring Team reviewed 11 acute illnesses and/or acute occurrences for eight individuals, including Individual #7 – bacterial pneumonia, and surgical procedure for fracture of femur; Individual #23 – impaired skin integrity; Individual #69 – risk for infection, and hyponatremia; Individual #466 – head injury, and cellulitis to the left foot; Individual #525 – acute sinusitis, and fracture; Individual #98 – fracture; and Individual #150 – soft tissue injury.

a. The acute illnesses/occurrences for which initial nursing assessments were performed consistent with current standards of practice included Individual #7 – surgical procedure for fracture of femur; Individual #69 – risk for infection; Individual #466 – head injury, and cellulitis to the left foot; and Individual #525 – acute sinusitis, and fracture. This indicator was not assessed for Individual #150's soft tissue injury, because the IPNs were not part of the document request.

b. This indicator was not applicable for Individual #69's hyponatremia, which was found through lab work. This indicator was not assessed for Individual #150's soft tissue injury, because the IPNs were not part of the document request. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #7 – surgical procedure for fracture of femur; Individual #69 – risk for infection; Individual #466 – head injury, and cellulitis to the left foot; Individual #525 – acute sinusitis, and fracture; and Individual #98 – fracture.

c. The acute illnesses/occurrences treated at the Facility for which licensed nursing staff conducted ongoing assessments were those for Individual #7 – bacterial pneumonia, Individual #525 – acute sinusitis, and Individual #98 – fracture.

d. Nursing staff conducted pre- and post-hospitalization assessments consistent with current standards of practice for Individual #7 – bacterial pneumonia, and surgical procedure for fracture of femur; and Individual #69 – risk for infection.

e. The acute care plan for Individual #525 included the basic clinical assessments necessary to address his acute sinusitis, even though some of the other interventions included did not define the specific criteria and frequency. For the remaining acute care plans, problems varied. However, the Facility should focus on ensuring acute care plans include instructions regarding follow-up nursing

assessments; identify the frequency with which monitoring should occur; are in alignment with nursing protocols; include specific goals that are clinically relevant, attainable, and realistic to measure the efficacy of interventions; and define the clinical indicators nursing will measure.

f. For Individual #525's acute sinusitis, nursing staff implemented the acute care plan as often as indicated by the individual's health status. Individual #525's record showed ongoing monitoring of the status of the acute sinusitis, and the sinusitis was sufficiently followed through to resolution.

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

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	83% 15/18	2/2	1/2	2/2	2/2	1/2	2/2	2/2	1/2	2/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #7 – constipation/bowel obstruction, and polypharmacy/side effects; Individual #23 – respiratory compromise, and UTIs; Individual #69 – skin integrity, and fractures; Individual #347 – constipation/bowel obstruction, and fractures; Individual #466 – behavioral health, and falls; Individual #525 – dental, and constipation/bowel obstruction; Individual #261 – UTIs, and constipation/bowel obstruction; Individual #98 – falls, and cardiac disease; and Individual #150 – constipation/bowel obstruction, and falls). None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #7 – constipation/bowel obstruction, and polypharmacy/side effects; Individual #23 – UTIs; Individual #69 – skin integrity, and fractures; Individual #347 – constipation/bowel obstruction, and fractures; Individual #466 – falls; Individual #525 – dental, and constipation/bowel obstruction; Individual #261 – UTIs, and constipation/bowel obstruction; Individual #98 – falls; and Individual #150 – constipation/bowel obstruction, and falls.

c. through e. Individual #69's ISP integrated reviews included data related to falls. However, because the goal was not clinically relevant, the IDT did not have data to determine if the individual was progressing, regressing, or remaining stable. Overall, without

clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
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	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

a. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner. The exception to this was Individual #69's IHCP related to skin integrity.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individual receives prescribed medications in accordance with applicable standards of care.	60% 9/15	0/1	1/1	1/2	1/2	1/1	1/2	0/2	2/2	2/2

b.	Medications that are not administered or the individual does not accept are explained.	17% 1/6	0/1	1/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A
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% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	83% 5/6	N/A	N/A	N/A	0/1	1/1	1/1	1/1	2/2	N/A
e.	Individual's PNMP plan is followed during medication administration.	86% 6/7	N/A	1/1	1/1	1/1	N/A	1/1	0/1	1/1	1/1
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/4	N/A	N/A	0/1	N/A	N/A	0/1	0/1	0/1	N/A
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/4	N/A	N/A	0/1	N/A	N/A	0/1	0/1	0/1	N/A
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	29% 2/7	0/1	1/1	0/1	0/1	1/1	0/1	0/1	N/A	N/A
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	33% 2/6	N/A	1/1	0/1	1/1	0/1	0/1	0/1	N/A	N/A

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of seven individuals, including Individual #7 (no observation), Individual #23, Individual #69, Individual #347, Individual #466 (deceased so no observation), Individual #525, Individual #261, Individual #98, and Individual #150.

a. and b.

- During the observation, Individual #23 refused his medications and the time allotted for administering the medications elapsed. Another Facility nurse prompted the medication nurse to get an order from the physician to give the medication after the allowed time. Up until the individual refused the medications, the nurse followed the procedure for medication

administration.

- For Individual #7, Individual #69, Individual #347, Individual #525, and Individual #261, the Monitoring Team identified unexplained Medication Administration Record (MAR) blanks. Of significant concern, the Monitoring Team identified 100 MAR blanks for Individual #261.
- During the onsite observation for Individual #261, the nurse did not let the medications flow into the gastrostomy tube by gravity, but rather she used a syringe to push them in, which is not consistent with accepted practice.

Although this did not negatively impact compliance, the Monitoring Team noted that nurses were documenting explanations for why medications were not given on the front of the MARs in the margins. This is not a usual practice in that usually the backs of the MARs are used for this information so as to not clutter the medication record with notes. The policy for this issue should be checked and/or clarified.

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

d. During the onsite observation, Individual #98 received Tylenol for pain, and the nurse told him what it was, and that it was given to decrease his pain. This was good to see.

e. and f. During the onsite observations with the exception of Individual #261, it was positive that for the individuals with PNMPs that the Monitoring Team observed, nursing staff followed the PNMPs as well as infection control practices.

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

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

i. and j. An ADR was reported for Individual #7 for Prolia.

k. and l. For Individual #347, there appeared to be significant delays in reporting medication variance (e.g., for missed doses of Keppra and Dilantin on 7/1/15, the variance forms were dated 7/10/15). The variance forms indicated: "unknown date of variance, unknown staff involvement and unknown time." However, the corrective action on these variance forms indicated that "meds are bagged per shift, per individual, per day," which would seem to indicate that a missed or extra dose should be found by the next shift. It was unclear if this was a facility procedure or an intervention for the individual or for the specific home.

Although not directly related to compliance with these indicators, from a quality assurance perspective, it is important to note that for Individual #7, a variance form dated 9/2/15 noted that eight to 10 Norco pills (i.e., a controlled drug for pain) were missing along with the Count sheets. Staff watched the video, but it did not appear to have shown anything. Based on review of the medication variance form, it was unclear if any corrective actions were identified to prevent a recurrence.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
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	0/1	N/A	0/2	N/A	0/1	0/2	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	89% 8/9		0/1		2/2		1/1	2/2	1/1	2/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9		0/1		0/2		0/1	0/2	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/9		0/1		0/2		0/1	0/2	0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/9		0/1		0/2		0/1	0/2	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;	44% 4/9	1/2	1/1	0/2	N/A	0/2	1/1	N/A	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	0/1	0/2		0/2	0/1		0/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	11% 1/9	0/2	1/1	0/2		0/2	0/1		0/1	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	11% 1/9	0/2	1/1	0/2		0/2	0/1		0/1	
	v. Individual has made progress on his/her goal/objective; and	0% 0/9	0/2	0/1	0/2		0/2	0/1		0/1	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/2	0/1	0/2		0/2	0/1		0/1	

Comments: The Monitoring Team reviewed nine goals/objectives related to PNM issues that six individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration for Individual #23; choking, and weight for Individual #347; choking for Individual #525; aspiration, and falls for Individual #261; aspiration for Individual #98; and choking, and falls for Individual #150.

a.i. and a.ii. Although it was good that most of these 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.

b.i. The Monitoring Team reviewed nine areas of need for six individuals that met criteria for PNMT involvement, including: fractures, and aspiration for Individual #7; weight for Individual #23; aspiration, and weight for Individual #69; aspiration, and choking for Individual #466; weight for Individual #525; and fractures for Individual #98. Individual #23, Individual #98, and Individual #525 were referred to the PNMT. Individual #7 was referred to the PNMT for fractures, but despite his history, the PNMT did not review his pneumonia event that occurred in August 2015 (i.e., there is mention of pneumonia, but no evidence of review). The PNMT did not review Individual #69's aspiration pneumonia event that occurred in January 2015. In addition, he had a 19-pound weight loss from February through March 2015, but the IDT did not refer him to the PNMT until he had lost 34 pounds (criteria is five pounds in a month). Individual #466 experienced an overall decline in functioning, particularly related to meals and safety of intake, but he was not referred to the PNMT (i.e., information the State provided after the review indicates that the IDT might have had end-of-life discussions, but based on documentation the Monitoring Team reviewed, such decisions were not documented clearly). Individual #466 died on 9/9/15, with causes of death listed as septic shock, aspiration pneumonia, dysphagia, and Down syndrome.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals. The goal that was measurable was the one for weight for Individual #23.

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
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.	11% 2/18	0/2	1/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	10% 1/10	0/2	0/1	0/2	N/A	0/2	0/1	N/A	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.	67% 2/3	N/A	1/1	0/1	N/A	N/A	N/A	N/A	1/1	N/A

Comments: a. As noted above, most IHCPs did not include all of the necessary PNM action steps to meet individuals' needs. In addition, the timeframes and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion. The IHCPs for which documentation was found to confirm the implementation of the PNM action steps were those for weight for Individual #23, and aspiration for Individual #261.

b. Individual #98's team referred him to the PNMT after he experienced a fracture.

c. On 9/9/15, the PNMT discharged Individual #23, and did a nice job sharing information with the IDT.

On 9/15/15, the PNMT discharged Individual #69, but there was no evidence of detailed information sharing with the IDT. On 9/15/15, an ISPA meeting occurred, but discussion only focused on changes to the PNMP, which was only part of what should have been discussed.

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

a.	Individuals' PNMPs are implemented as written.	33% 13/40
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.	17% 1/6
Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during seven out of 22 observations (32%). Staff followed individuals' dining plans during five out of 17 mealtime observations (29%). Transfers were completed according to the PNMPs in one of one observation (100%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A	N/A		N/A				N/A		
Comments: This indicator was not applicable to the individuals reviewed with enteral nutrition.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	10% 1/10	0/1	0/1	1/2	0/2	N/A	0/1	0/1	0/1	0/1

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	10% 1/10	0/1	0/1	1/2	0/2		0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/10	0/1	0/1	0/2	0/2		0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/10	0/1	0/1	0/2	0/2		0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/2	0/2		0/1	0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed 10 OT/PT-related goals/objectives and/or areas of need for eight individuals. The goal/objective that was clinically relevant/achievable, and measurable was Individual #69's goal for bilateral upper extremity improvement. In a number of cases, the OT/PT assessment recommended goals or areas in which the individual would benefit from a training program or the ISP narrative indicated the need for such goals, but without justification, IDTs did not include them in ISP action plans (e.g., Individual #7, Individual #23, Individual #69, Individual #347, Individual #525, Individual #261, and Individual #150).

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were 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. Based on review of Individual #466's OT/PT assessment and ISP, he did not need an OT/PT-related goal, but he was part of the core sample, so a full review was conducted for him. Full reviews were completed for the remaining eight individuals as well.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	18% 2/11	1/1	1/1	0/2	0/2	0/1	0/1	0/1	0/1	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/3	0/1	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A

Comments: a. The OT/PT strategies/action plans that were implemented were the PNMT monitoring of safe strategies for Individual #7's transfers, and for Individual #23, a PT assessment for a walking program.

b. For Individual #525, no ISPA documentation was found showing IDT discussion of discharge from direct therapy. For Individual #7 and Individual #69, meetings were not held to discuss the results of the assessments/supports IDTs requested.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
			Individuals:								
#	Indicator	Overall Score	23	413	311	489	147	528	485	266	345
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	94% 33/35	1/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	89% 31/35	1/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	71% 25/35	1/3	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		42	344	204	535	5	261	80	14	443
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
		Individuals:									
#	Indicator		499	53	403	431	275	520	77	73	140
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	2/2	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	0/1	0/1	1/1	1/1	1/1	1/1	2/2	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	0/1	0/1	1/1	0/1	1/1	1/1	2/2	1/1
		Individuals:									
#	Indicator		255	312	92	498	112				

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1				
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1				
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	0/1	1/1				

Comments: a. The Monitoring Team conducted observations of 35 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment, which was good to see. The exceptions were Individual #23's hand splints and elbow pillows.

b. For Individual #23, the Velcro on his hand splints was worn, and staff reported they were hard to keep strapped. In addition, his elbow pillows were worn down on the forearm and wrist, but not at the elbow. Individual #53's palm protectors were unstrapped and twisted. Individual #403's elbow pillows were unstrapped and around his wrist.

c. As noted above, issues with proper fit were noted with Individual #23's hand splints and elbow pillows, Individual #53's palm protectors, and Individual #403's elbow pillows. Based on observation of Individual #147, Individual #345, Individual #80, Individual #275, and Individual #498 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

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

ISPs

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

			Individuals:								
#	Indicator	Overall Score	303	301	525	98	23	7			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

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

4-7. Overall, personal goals were undefined. Therefore, there was no basis for assessing progress in these areas. Revisions to supports did not generally occur when individuals were not making progress (or if plans were not implemented). There was no documentation to show that the IDT met to discuss their lack of progress or revised the ISP to address any barriers to achieving outcomes.

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

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

			Individuals:								
#	Indicator	Overall Score	303	301	525	98	23	7			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									

Comments:
39-40. A review of data sheets, QIDP monthly reviews, and observations while onsite did not support that action plans were being consistently implemented.

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.

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
6	The individual is progressing on his/her SAPS	0% 0/23	0/3	0/3	0/2	0/3	0/3	0/3	0/3	0/2	0/1
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/18	0/2	0/3	0/2	0/2	0/1	0/3	0/2	0/2	0/1
9	Decisions to continue, discontinue, or modify SAPs were data based.	0% 0/23	0/3	0/3	0/2	0/3	0/3	0/3	0/3	0/2	0/1

Comments:
6. Because there was no system for assessing the reliability of the data, it was not possible to determine an individual's progress on his/her SAPs. Further, graphs that were provided suggested that training opportunities were quite limited for many SAPs (e.g., Individual #482 shopping, Individual #441 choice making, Individual #301 writing a card, Individual #405 laundry and hand washing). On at least seven other SAPs, data reflected limited progress (e.g., Individual #482 schedule, Individual #441 napkin disposal, Individual #318 laundry and tying bundles, Individual #525 ambulation and bathing, Individual #549 toileting). For others, the data depicted in the graphs did not correspond to the information recorded on the raw data sheets (e.g., Individual #303 working, playing game, applying sunscreen; Individual #405 bed making).

7. Individual #318 was observed independently using his communication book. Clearly this objective had been met, but a new or updated objective had not been introduced.

8. There were problems with the timely identification and development of alternative programs when SAPs were discontinued. For example, Individual #303 had a dishwashing SAP that was discontinued 14 days after his ISP meeting. A replacement was never identified. Individual #549 had two of three SAPs discontinued sometime before 6/28/15, yet replacement SAPs were not introduced until 11/18/15. For other individuals (e.g., Individual #482 schedule, Individual #318 tie bundles, Individual #301 write cards), SAPs were neither revised nor replaced even when progress was not evident for several months. While the IDT met for Individual #482 on 7/20/15 to recommend the development of a cooking SAP, this had not been addressed at the time of the visit. When the Monitoring

Team requested a copy of this SAP while onsite, the Program Development Specialist indicated that this was the first she had learned of this request.

9. The facility provided an untitled document for each individual in which SAP data were presented in graphic form. However, when reviewing available QIDP Monthly Reviews and IDT Monthly Reviews, reports regarding progress on SAPs did not reference data.

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
13	The individual's SAPs are complete.	17% 4/23	0/3	1/3	0/2	0/3	1/3	1/3	1/3	0/2	0/1

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Teaching methodology was not correctly identified in most SAPs. For example, the healthy choices and shopping SAPs for Individual #482 indicated these were behavior chains. However, a review of the training steps revealed multiple discrete skills. The same was true in the cleaning SAP for Individual #301.

In other cases, chaining was the identified methodology, when in fact, shaping was the strategy described (e.g., Individual #303 begin working, play a game). While training schedules were included in the majority of SAPs, these often reflected limited opportunities for the individual to learn the skill. Praise was often the sole identified reinforcer for correct responding. Staff should consider individual specific reinforcers, particularly when progress is limited or the individual repeatedly refuses to participate. Staff are advised to include collection of baseline measures on the terminal objective prior to beginning training/teaching.

Outcome 5- SAPs are implemented with integrity.

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
14	SAPs are implemented as written.	20% 1/5	0/1	N/A	0/1	0/1	0/1	N/A	1/1	N/A	N/A
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/23	0/3	0/3	0/2	0/3	0/3	0/3	0/3	0/2	0/1

Comments:
14. A specific SAP training session was observed for five individuals (Individual #482, Individual #441, Individual #318, Individual #301, Individual #525). Only Individual #525's SAP was implemented as described in the SAP. Staff provided effective support, including singing songs to help motivate Individual #525 to walk. While Individual #301's SAP was not implemented as written, it was

actually completed in a more logical format. It should be noted that the staff member working with Individual #301 did a very good job limiting her verbal instruction to ensure that the skill was completed as independently as possible.

15. The facility did not have a system for ensuring integrity of SAP implementation. While it was suggested that the individual's QIDP will be responsible for SAP integrity, the facility is advised to first ensure that the QIDP understands the SAP and can implement it with integrity.

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
16	There is evidence that SAPs are reviewed monthly.	0% 0/23	0/3	0/3	0/2	0/3	0/3	0/3	0/3	0/2	0/1
17	SAP outcomes are graphed.	100% 23/23	3/3	3/3	2/2	3/3	3/3	3/3	3/3	2/2	1/1

Comments:
16. Although QIDP Monthly Reviews were provided for Individual #482, Individual #303, Individual #318, Individual #301, and Individual #405, the facility noted these were not available for Individual #441, Individual #525, Individual #98, and Individual #549. Further, progress on all SAPs was not always addressed. For example, Individual #482's reports either did not comment on SAPs (healthy choices and shopping) or noted that the SAP (schedule) was not in her chart at the time of review. There was no mention of Individual #303's progress on his working SAP for four consecutive months. For Individual #318 (tying bundles) and Individual #301 (writing a card), the current step was noted, but there was no report regarding progress. None of Individual #405's SAPs were reviewed for the two consecutive monthly reports that were provided.

17. Graphs depicting progress were provided in an untitled document for all individuals. Regrettably, these data were not included in either the QIDP Monthly Reviews or the recently introduced IDT Monthly Reviews.

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

			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
18	The individual is meaningfully engaged in residential and treatment sites.	38% 3/9	0/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	13% 1/8	0/1	1/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1

Comments:
18. Levels of engagement varied considerably across individuals. For example, when observed, Individual #301 was consistently engaged. She participated in multiple work activities, including community-based employment, work at the facility diner, and daily attendance at workshop. Although Individual #482 was observed preparing to go out to lunch or watching television, there were multiple visits to her home when she was in her bedroom. Her program reflected very limited opportunity for personal development.

Others (e.g., Individual #441, Individual #405, Individual #525, Individual #549) were not engaged, particularly on the home. Individual #525 was most often observed sitting in his recliner. His PBSP indicated that he should be kept away from peers when in his wheelchair, but there were concerns that the frequent use of the recliner resulted in an unplanned form of restraint. With the exception of Individual #301, the individuals had limited opportunities for meaningful engagement in a range of interesting and functional activities.

19-21. The facility had initiated a system for regularly reviewing engagement across home, work, and day activity environments. Each site had also established a goal level regarding engagement. These ranged from 51% to 90% in the homes, 40% to 80% in the activity/senior centers, and 90% in the workshops. During the reporting period, goal levels had been achieved in three homes, two workshops, and one activity center. Since April 2015, at least one measure of engagement had been collected in each setting. Inter-rater reliability had been introduced in June 2015. This was a commendable undertaking.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
			Individuals:								
#	Indicator	Overall Score	482	303	441	318	301	405	525	98	549
22	For the individual, goal frequencies of community recreational activities are established and achieved.	56% 5/9	0/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	17% 1/6	0/2	N/A	N/A	0/1	1/2	N/A	N/A	N/A	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% 0/4	0/1	N/A	N/A	N/A	N/A	N/A	0/1	0/1	0/1

Comments:
22. Information provided for Individual #303, Individual #441, Individual #318, Individual #405, and Individual #549 suggested that they either met or exceeded their goal frequencies for community-based recreational activities. While community-based recreational activities were not identified in the ISPs for either Individual #482 or Individual #301, both individuals clearly experienced fairly

frequent trips into the community.

23. Four individuals (Individual #482, Individual #318, Individual #301, Individual #549) had SAPs in which the community was identified in the ISP as a possible training site. Goal frequencies were not identified.

24. The lack of community-based training was not addressed in the monthly reviews or in any available ISPAs.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.												
			Individuals:									
#	Indicator	Overall Score										
25	The student receives educational services that are integrated with the ISP.	N/A										
Comments: 25. This outcome and indicator did not apply to any of the individuals chosen for review.												

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.											
			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2								0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2								0/1	0/1
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2								0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2								0/1	0/1
Comments: Individual #98 and Individual #150 had documented refusals over the last 12 months, but neither had goals/objectives in their IHCPs to address the refusals. Individual #150 had an action step that potentially could assist in addressing refusals: "will be assessed by dentistry for a desensitization program to assist in behaviors for in office visits in the next 12 months." However, the											

desensitization program remained undeveloped, and no timeline was provided for completion and implementation. His oral hygiene had regressed, but the IDT had not met to discuss ways to reverse this trend.

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.

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	44% 4/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1

Comments: a. and b. The ISPs that included clinically relevant and achievable goals/objectives to address individuals' communication needs were those for Individual #261, and Individual #150. Individual #525 and Individual #98's goals/objectives were also measurable, including timeframes for completion.

c. through e. Individual #261 made limited to no progress on her communication goal from 6/29/15 to 9/21/15. The IDT met as part of the annual ISP and revised the goal in an attempt to make it more meaningful, which was good to see. Individual #261 was part of the core sample, so the Monitoring Team conducted a full review. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.

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

			Individuals:								
#	Indicator	Overall Score	7	23	69	347	466	525	261	98	150
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1

	implemented.										
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. For Individual #261, the IDT changed the goal for using a radio to small talk. This was noted in the ISP, and reviewed as part of the ISP integrated report. For other individuals, problems varied, but included a lack of any implementation, statements made about progress without citation of data to substantiate the findings, and/or no ISP integrated reports to show implementation and analysis of data.											

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.											
			Individuals:								
#	Indicator	Overall Score	458	261	377	485	489	3	5	147	150
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	17% 2/12	0/1	0/1	0/1	0/1	0/1	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.	8% 1/12	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
			Individuals:								
#	Indicator		73	312	318						
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						
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						
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/5									
Comments: a. and b. Individual #377's staff prompted the use of the device prior to dining, but upon entering the dining room, removed the device. c. It appeared that the lack of instructions SLPs provided to staff regarding how to use the AAC devices, when to use the devices, and the function of the devices resulted in a clear lack of staff understanding, and consequently, staff were not observed facilitating use of the AAC devices with individuals.											

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

    c. Medical
    d. Nursing
    e. Pharmacy
    f. Dental
- List of Medication times by home
- All DUE reports completed over the last six months (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results)
- For all deaths occurring since the last review, the recommendations from the administrative death review, and evidence of closure for each recommendation (please match the evidence with each recommendation)
- In alphabetical order, name of individual and list of his/her adaptive equipment
- By home, name of individual and list of his/her adaptive equipment
- 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, and previous IRRF
- 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, documentation of committee or group discussion related to use of medication/anesthesia, and Medical/Dental Restraint Checklist, as applicable
- 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
- For any extraction, the signed informed consent form(s)s
- Documentation of the Pharmacy's review of the five most recent new medication 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
- 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
- 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, including, as applicable, any relevant documentation of discussions with State Office, including the legal department
- For individuals requiring suction tooth brushing, last three months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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