United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

Dates of Onsite Review: August 29th through September 2nd, 2016

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Table of Contents

Background	2
Methodology	3
Organization of Report	4
Executive Summary	4
Status of Compliance with Settlement Agreement	
Domain 1	6
Domain 2	28
Domain 3	71
Domain 4	115
Domain 5	126
Appendices	
A. Interviews and Documents Reviewed	140
B. List of Acronyms	148

Background

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

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

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

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

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

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

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

Methodology

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

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

move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement.

Organization of Report

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

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

Executive Summary

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.

As was discussed with the Facility Director and State Office staff during the onsite review, the Monitoring Team identified a number of concerns with regard to the implementation of Habilitation Therapy protections, supports, and services. In summary:

- The Physical and Nutritional Management Team (PNMT) was not consistently providing needed reviews and/or assessments for individuals with physical and nutritional management-related needs that met criteria for referral to and/or review by the PNMT.
- In addition, when the PNMT completed assessments, they were not timely, and many issues were identified with regard to the quality of the assessments. For example, the PNMT had not consistently identified the etiology/cause of the problem, and the steps necessary to mitigate risk. Similarly, the analysis of the effectiveness of current supports often was not clear, making it unclear what, if anything, needed to change. The PNMT often did not clearly define individualized clinical indicators to assist Interdisciplinary Teams (IDTs) in identifying when the individual was healthy and/or when deterioration was potentially occurring. In addition, disciplines that should have been involved in the PNMT assessment were not.
- Minimal, if any, improvement was noted with regard to the timeliness or quality of OT/PT comprehensive assessments and updates. Of particular concern, was the significant deficits noted in relation to the OT/PT updates. They did not provide IDTs with the information needed to identify individuals' current strengths and needs, and develop plans to meet their needs while incorporating their preferences.
- Based on observations, there were still numerous instances (67% of 40 observations) in which staff were not implementing individuals' Physical and Nutritional Management Plans (PNMPs) or were implementing them incorrectly. This was particularly concerning given that PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

As a result, the Lead Monitor requested that the Facility review and revise, as necessary its action plan for complying with these components of the Settlement, and provide the Monitoring Team with a copy. Center staff are encouraged to review the detailed findings in this report, and utilize this information to refine the action plan, and implement remedies to the issues identified.

Status of Compliance with the Settlement Agreement

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

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Nine of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This included one outcome: Outcome #5 for Abuse, Neglect, and Incident Management.

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

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

Restraint

The overall usage of crisis intervention restraint at Abilene SSLC remained in the middle compared to the other facilities, though a slightly ascending trend that was occurring requires attention from the behavioral health services and quality assurance departments. Crisis intervention restraint, when used, was implemented in a safe manner and as required by policy. Staff who were responsible for providing restraint were knowledgeable regarding approved restraint practices. Even so, there remained a number of areas for focus, including ensuring restraint was used only when there is immediate risk of injury, that supports and services are in place to reduce the likelihood of behaviors occurring that necessitate crisis intervention restraint, full completion of all documentation, and full implementation of all recommendations that come from post-restraint review.

As part of restraint monitoring, nursing staff need to improve their documentation of individuals' mental status. In addition, nurses need to provide more detailed descriptions, including specific comparisons to the individual's baseline.

Abuse, Neglect, and Incident Management

Abilene SSLC has struggled with meeting the various requirements of appropriate reporting of allegations. The score for this review was lower than last time. The problems included failure to report, failure to report within proper timelines and/or to the proper people, lack of detail in the UIR, and not resolving conflicting information regarding specific reports. This is an area requiring focus by the facility and its management.

Investigations need to be more comprehensive in that all relevant staff named in the UIR need to be interviewed, or a reason as to why not needs to be presented in the UIR. Supervisory review did not capture the problems with staff interviews. Supervisory review, however, did capture problems with some of the late reporting occurrences, which was good to see.

Trend analysis and related QA activity did not identify serious trends. Moreover, the QAQI Council minutes did not contain any recommendations. Given the issues identified in this report, it was evident that the Abilene SSLC QA review process was not sufficiently robust. A particularly salient example was for Individual #69, whose history of fractures was not addressed. Moreover, the high number of fractures at Abilene SSLC was a facility-wide problem that was not specifically addressed by the QA or incident management departments. The facility should ensure that serious injuries are examined at the individual level, and at the facility level.

<u>Other</u>

Overall, pretreatment chemical restraint practices needed more focus in order to meet the outcomes and indicators evaluated by the Monitoring Teams.

It was good to see that the Center completed clinically significant DUEs and followed up to closure on recommendations.

<u>Restraint</u>

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: The frequency of use of crisis intervention restraint at Abilene SSLC remained in the middle compared to the other facilities and also showed a slightly increasing trend. Ongoing attention to the number of individuals who receive crisis intervention restraint will require continued focus. These two important indicators scored slightly lower than during the last review and both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	67% 8/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	44% 4/9	0/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1
Comments: 1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (October 2015 through June 2016) were reviewed. Overall, the frequency of use of crisis intervention restraint was slightly ascending over the course of the nine-month											

period and certainly when looking at the previous 14-month period. Compared to the other facilities, and using the census-adjusted rate, Abilene SSLC was in the middle, that is, six facilities had higher rates and six had lower rates. Given this and the ascending trend, this measure was not scored as meeting criterion. Given that the majority of crisis intervention restraints were physical restraints, the same trend was seen for crisis intervention physical restraints. The average duration of crisis intervention physical restraints was decreasing across this period. The use of crisis intervention chemical restraint remained very low, and the use of crisis intervention mechanical restraint only occurred once.

There was a decreasing trend in the number of injuries that occurred as a result of crisis intervention restraint implementation. All were deemed non-serious. Even so, these should continue to be examined by the restraint reduction committee/QA to ensure that restraints are being implemented properly. Also worthy of further examination is the number of individuals who received crisis intervention restraint each month because there was a slightly increasing trend. The number of individuals who had protective mechanical restraint for self-injurious behavior remained at zero.

The number of chemical restraints for medical procedures was increasing. The number of non-chemical restraints for medical procedures decreased across the review period. The number of chemical and non-chemical restraints for dental procedures remained stable and low.

Thus, state and facility data showed low usage and/or decreases in eight of these 12 facility-wide measures (i.e., duration of physical restraints, use of chemical and mechanical crisis intervention restraints, injuries during restraint, use of protective mechanical restraint for self-injurious behavior, non-chemical medical restraints, and chemical and non-chemical dental restraints).

2. Seven of the individuals reviewed by the Monitoring Team were subject to restraint. All seven received crisis intervention physical restraints (Individual #95, Individual #530, Individual #93, Individual #570, Individual #554, Individual #474, Individual #225), and one also received crisis intervention chemical restraint (Individual #570). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for two (Individual #93, Individual #225). The other two individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

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

Summary: Overall, Abilene SSLC implemented restraint according to most of the criteria in this outcome. For instance, three of the indicators have had high scores for multiple reviews and will be moved to the category of requiring less oversight (3, 4, 6). Focus upon the other indicators is needed and they will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 95	530	93	570	554	474	225		
3	There was no evidence of prone restraint used.	100% 10/10	2/2	1/1	1/1	3/3	1/1	1/1	1/1		

4	The restraint was a method approved in facility policy.	100% 10/10	2/2	1/1	1/1	3/3	1/1	1/1	1/1		
5	The individual posed an immediate and serious risk of harm to him/herself or others.	80% 8/10	2/2	0/1	1/1	3/3	1/1	1/1	0/1		
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 7/7	2/2	N/A	1/1	2/2	1/1	1/1	N/A		
7	There was no injury to the individual as a result of implementation of the restraint.	60% 6/10	0/2	1/1	1/1	2/3	1/1	1/1	0/1		
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	90% 9/10	2/2	0/1	1/1	3/3	1/1	1/1	1/1		
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	38% 3/8	2/2	0/1	Not rated	0/3	0/1	1/1	Not rated		
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	80% 8/10	2/2	0/1	1/1	2/3	1/1	1/1	1/1		
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	80% 8/10	2/2	0/1	1/1	3/3	1/1	0/1	1/1		

Comments:

The Monitoring Team chose to review 10 restraint incidents that occurred for seven different individuals (Individual #95, Individual #530, Individual #93, Individual #570, Individual #554, Individual #474, Individual #225). Of these, nine were crisis intervention physical restraints, and was a crisis intervention chemical restraint. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

5. For Individual #530 3/28/16, the facility's post restraint review concluded that an immediate and serious risk did not exist and that staff overreacted and performed an unnecessary restraint. For Individual #225 4/16/16, the restraint checklist said aggression to staff. More detail was needed in order to determine that the individual posed an immediate and serious risk of harm.

7. The restraint checklist indicated injury for three of the restraints. As noted in indicator 1, these were all deemed to be not serious injuries (but should still be reviewed). For Individual #225 4/16/16, there was no entry on the restraint checklist.

8. Given that the restraint for Individual #530 3/28/16 was performed unnecessarily, the restraint did not meet criterion for this indicator.

9. Because criterion for indicator #2 was met for two of the seven individuals, this indicator was not scored for them. For the other five, the various aspects of support were in place for three restraints for two of the individuals (Individual #95, Individual #474). For the five restraints for the other three individuals, components of the ISP and/or PBSP were not being implemented, individuals were

	not regularly engaged in activities, and/or strategies to reduce the likelihood of restraint were not implemented (Individual #530, Individual #570, Individual #554). 10. For Individual #530 3/28/16 and for Individual #570 5/14/16, while the restraint checklist has all the boxes checked, post restraint review showed that implementation of pre-restraint actions most likely did not occur. 11. The restraint consideration section of the ISP IRRFs was not correctly completed for Individual #530 and Individual #474.										

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: Staff correctly answered questions about the usage of crisis intervention restraint. This indicator was scored at 100% for this review, an improvement from the last review. With sustained performance, this indicator might move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	554	474	225		
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 6/6	1/1	1/1	Not rated	1/1	1/1	1/1	1/1		
	Comments: 12. Because criteria for indicators 2-11 were met for Individual #93, this indicator was not scored for her.										

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: Four of 10 restraints did not have proper restraint monitor activity. The percentage of restraints that met criteria for this indicator had declined over this and the previous two reviews. This is an area of focus for the facility. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	554	474	225		
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	60% 6/10	1/2	0/1	1/1	2/3	1/1	1/1	0/1		
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
	Comments:										

13. For Individual #95 6/17/16, the face-to-face assessment document showed that the restraint was initiated at 20:58 and restraint monitor arrived at 21:14, one minute beyond the 15 minute requirement. For Individual #530 3/28/16, the face-to-face assessment document showed that the restraint was initiated at 15:16 and the restraint monitor arrived at 15:38, that is, after 22 minutes.

For Individual #570 6/22/16, the face-to-face assessment document showed that the restraint was initiated at 14:03 and the restraint monitor arrived at 18:49, that is, more than four hours later. The restraint occurred off campus, accounting for the delay, but the facility should have ensured that a staff trained as a restraint monitor was part of the group because Individual #570 (and maybe others) were at high risk for behavioral episodes that could result in crisis intervention restraint.

For Individual #225 4/16/16, the face-to-face assessment document did not show the time that the restraint monitor arrived.

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: As part of restraint monitoring, nursing staff need to improve their documentation of individuals' mental status. Nurses need to provide more detailed descriptions, including specific comparisons to the individual's baseline. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	554	474	225		
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	33% 3/9	0/2	0/1	1/1	0/2	0/1	1/1	1/1		
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	67% 6/9	0/2	1/1	1/1	2/2	1/1	1/1	0/1		
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	22% 2/9	0/2	0/1	1/1	0/2	0/1	1/1	0/1		

Comments: The crisis intervention restraints reviewed included those for: Individual #95 on 1/19/16 at 8:08 p.m., and 6/17/16 at 8:58 p.m.; Individual #530 on 3/28/16 at 3:16 p.m.; Individual #93 on 4/11/16 at 7:26 p.m.; Individual #570 on 5/14/16 at 2:35 p.m., and 6/22/16 at 6:03 p.m.; Individual #554 on 5/23/16 at 3:40 p.m., Individual #474 on 5/25/16 at 7:28 p.m.; and Individual #225 on 4/16/16 at 8:16 a.m.

a. For five of the nine restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #530 on 3/28/16 at 3:16 p.m.; Individual #570 on 5/14/16 at 2:35 p.m., and 6/22/16 at 6:03 p.m. (i.e., for whom the second restraint occurred off campus, but the documentation provided did not indicate what time he returned to the Center); and Individual #554 on 5/23/16 at 3:40 p.m. (for whom the restraint occurred at school, but no information was provided regarding what time the individual returned to the Center).

For six of the nine restraints, nursing staff monitored and documented vital signs. The exceptions were for Individual #95 on 1/19/16

at 8:08 p.m. (initial set of vitals indicated "refused" for respirations, but the individual's cooperation is not needed); and Individual #570 on 5/14/16 at 2:35 p.m., and 6/22/16 at 6:03 p.m. (no vital signs documented). On 5/14/16, Individual #570 received a chemical restraint of 50 milligrams (mg) of Thorazine. Vital signs should have been obtained as soon as the individual was cooperative, but the IPNs did not include a full set of vital signs, although respirations were consistently obtained.

Nursing staff monitored and documented the mental status of the individuals for three of the nine restraints. Often, mental status was documented as "awake, and alert," or "within normal limits." Nurses need to provide more detailed descriptions, including specific comparisons to the individual's baseline.

b. Examples of problems included:

- For the restraint of Individual #95 on 1/19/16 at 8:08 p.m., the Center did not provide an injury report for the injury the nurse noted on the right side of the rib cage under the individual's armpit (abrasion) "due to restraint." Also, the IPN did not include a description of the abrasion (e.g., size, length, color, open, bleeding).
- For the restraint of Individual #95 on 6/17/16 at 8:58 p.m., the Center did not provide an injury report for a hit to the right side of the individual's head on a dresser "while being followed down to the floor" during a two-person horizontal restraint, as noted in an IPN on 6/17/16 at 9:15 p.m. The IPN describing the injury was very complete and noted that an injury report was completed, but it was not provided.
- For the restraint of Individual #225 on 4/16/16 at 8:16 a.m., the injury section of the restraint checklist was left blank, and the IPN for this episode did not note the presence or absence of injuries.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	554	474	225		
15	Restraint was documented in compliance with Appendix A.	80% 8/10	2/2	1/1	0/1	2/3	1/1	1/1	1/1		
Comments: 15. For Individual #93 4/11/16, there was no entry regarding level of supervision during restraint. For Individual #570 5/14/16, the names of staff involved did not include a nurse regarding who applied the restraint for this crisis intervention chemical restraint.											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: Reviews of restraint occurred some, but not all of the time. Recommendations, when made, were implemented. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	554	474	225		
16	For crisis intervention restraints, a thorough review of the crisis	70%	1/2	1/1	1/1	3/3	0/1	1/1	0/1		

	intervention restraint was conducted in compliance with state policy.	7/10									
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	50% 3/6	0/1	1/1	1/1	1/1	0/1	N/A	0/1		

Comments:
16-17. For Individual #95 6/17/16, the document provided by the facility that summarized unit and incident review team discussion did not have any entries. For Individual #554 5/23/16, the individual did not have a crisis intervention plan, so there should have been a post restraint ISPA, but there wasn't. For Individual #225 4/16/16, documentation on the face-to-face assessment was incomplete and this could not be determined.

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

Summary: Indicators 48 and 49 met criteria for this review and for the last two reviews, too. Therefore, they will move to the category of requiring less oversight. With sustained performance, indicator 47 might also move to the category of requiring less oversight after the next review.

Individuals:

#	Indicator	Overall Score	570								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								
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. There was one individual in the review group who received chemical restraint during this review period (Individual #570). Only one medication was used and the review by the Pharm.D and the psychiatrist occurred within the required time frame. There was also documentation of additional follow-up by the psychiatrist after the incident.

Abuse, Neglect, and Incident Management

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

Summary: Abilene SSLC improved performance on this indicator, which was good to see. The Monitoring Team was concerned, however, that Individual #69's history of fractures was not addressed as required by this indicator and that this was the only investigation that examined serious injury. The facility should ensure that serious injuries are examined at the individual level, and at the facility level

Individuals:

(outcome 10). This indicator will remain in active monitoring.											
#	Indicator	Overall Score	95	93	570	474	222	225	69	446	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	90% 9/10	1/1	1/1	3/3	1/1	1/1	1/1	0/1	1/1	

Comments:
The Monitoring Team reviewed 10 investigations that occurred for eight individuals. Of these 10 investigations, seven were DFPS investigations of abuse-neglect allegations (three confirmed, four unconfirmed). The other three were for facility investigations of a discovered back fracture, unauthorized departure, and a suicidal threat with law enforcement contact. 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 #95, UIR 4049, DFPS 44163617, unconfirmed allegation of physical abuse, 12/23/15
- Individual #93, UIR 4527, DFPS 44364706, unconfirmed allegation of neglect, 5/24/16
- Individual #570, UIR 4109, DFPS 44180634, confirmed allegation of neglect, 1/10/16
- Individual #570, UIR 4328, DFPS 44280674, unconfirmed allegation of physical abuse, 3/24/16
- Individual #570, UIR 4619, suicidal threat, encounter with law enforcement, 6/22/16
- Individual #474, UIR 4109, DFPS 44180634, unconfirmed allegation of neglect, 1/10/16
- Individual #222, UIR 4027, DFPS 44151252, confirmed allegation of physical abuse II, 11/8/15
- Individual #225, UIR 4315, DFPS 44278625, unconfirmed allegation of verbal abuse, 3/24/15
- Individual #69, UIR 4173, discovered injury, fracture, back, 2/4/16
- Individual #446, UIR 4477, unauthorized departure, 5/3/16

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

Nine of the 10 investigations met the relevant criteria. Six of these nine involved allegations of staff abuse or neglect actions that did not relate to any trends of prior incidents or related occurrences. Therefore, only criterion (a) applied, and it was met. The other three that met criteria involved a likely spurious allegation likely made by the individual, this behavior was addressed in the individual's PBSP (Individual #95 UIR 4049), good detail was in an ISPA as well as presence of a related PBSP (Individual #570 UIR 4619), and there was detail in the ISP and monthly reviews regarding the related PBSP (Individual #446 UIR 4477).

The investigation that did not meet criteria was for Individual #69 UIR 4173 because he had a history of fractures, but no actions were demonstrated that met criteria b, c, and d. Moreover, the high number of fractures at Abilene SSLC was a facility-wide problem that was

not specifically addressed by the QA or incident management departments. Also see comments in outcomes 6, 7, and 10 below.

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

Summary: Abilene SSLC has struggled with meeting the various requirements of appropriate reporting of allegations. The score for this review was lower than last time. Moreover, the scores for Abilene SSLC for this indicator for the last two reviews were the lowest scores across all 13 facilities. The problems included failure to report, failure to report with proper timelines and/or to the proper people, lack of detail in the UIR, and not resolving conflicting information around reporting. This is an area requiring focus by the facility and management. Perhaps it should become an area that the QA department helps monitor and support. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 95	93	570	474	222	225	69	446	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	30% 3/10	0/1	0/1	1/3	0/1	0/1	0/1	1/1	1/1	

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 #95 UIR 4049: The alleged incident occurred on 12/22/15 and was reported to DFPS on 12/24/15. It appeared possible/likely that the incident was reported by the individual or his family. In these types of cases, the facility should attempt to validate this, so that it can determine (in its review of the incident/investigation) if reporting timelines were met. Furthermore, DFPS reported incident to the facility on 12/24/15 at 10:51 am. The UIR showed that facility director/designee notification occurred on 12/28/15 at 8:30am. The UIR did not show any administrator-type of notification.
- Individual #93 UIR 4527: In this case, the UIR noted that the allegation was called in by the individual. According to the UIR, a staff was aware of this, but did not report this to the facility director/designee. The UIR noted that she will be retrained on reporting procedures. This was good to see.
- Individual #570 UIR 4109 and Individual #474 UIR 4109: The DFPS report and the UIR showed that the incident occurred on 1/10/16 and was reported on 1/11/16. It seemed that this may have been reported after a video review by the facility, but there was not enough definitive information in the UIR to confirm this.
- Individual #570 UIR 4328: The UIR and the DFPS report showed that the incident occurred on 3/24/16 and was reported on 3/28/16. There was no information in either document to address this. The IMC review (post investigation) noted this was a

late report, but did not explain the circumstances which would have been helpful in addressing training to avoid something similar happening in the future.

- Individual #222 UIR 4027: Per DFPS and the UIR, the incident occurred on 11/8/15 and was reported on 12/14/15 after a behavior analyst was reviewing video. (The 11/8/15 was corrected to be 12/8/15 after the facility did its post investigation review.) Per DFPS, two other staff were in the video and observed the inappropriate actions by alleged perpetrator. They should have reported it, but didn't.
- Individual #225 UIR 4315: Per DFPS, the incident occurred on 3/24/16 and was reported on 3/25/16. Per the UIR, however, the incident occurred on 3/25/16 and was reported on 3/25/16. The UIR did not contain sufficient information to explain the reporting sequence to enable a determination of timely reporting. Post investigation review by the IMC did note that this was a late report.

Proper reporting is an area requiring focus by the facility. The facility needs to develop a process, so that each UIR includes the making of an explicit determination as to the circumstances surrounding a report and whether or not timeliness requirements were met. See outcome summary above.

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

Summary: These three indicators all showed improvement since the last review. With sustained performance, they might move to the category of requiring less oversight after the next review. For indicator 3, even though the score is high, given the problems in reporting detailed in indicator 2 above, the facility should continue to focus on staff training regarding reporting requirements. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 95	93	570	474	222	225	69	446	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 2/2	Not rated	Not rated	Not rated	1/1	Not rated	Not rated	1/1	Not rated	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	88% 7/8	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 10/10	1/1	1/1	3/3	1/1	1/1	1/1	1/1	1/1	

Comments:

4. Criteria were met for all individuals, except the required posting of reporting information was in a locked office in Individual #95's home, inaccessible to those who might need it.

5. There was a concern about retaliation in Individual #222 UIR 4027. It was addressed by the facility via administrative review and

follow-up action. This was good to see.

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

Summary: Abilene SSLC met criterion for this indicator for all but one of the investigations. Due to the importance of reassignment of alleged perpetrators, this indicator will remain in active monitoring, but with sustained performance, as was demonstrated during the last two reviews, which were at 100% and 88%, respectively, this indicator might move to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 95	93	570	474	222	225	69	446	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	90% 9/10	1/1	0/1	3/3	1/1	1/1	1/1	1/1	1/1	

Comments:
6. For Individual #93 UIR 4527, the DFPS report showed two named alleged perpetrators. The UIR, however, did not show reassignment. The IMC's review in the UIR, though, noted a discrepancy in the DFPS five-day report (no alleged perpetrators were identified) and the DFPS final report (where the two were identified). At the point that DFPS determines there are named alleged perpetrators, this should be reported to the facility. Not doing so compromises client protection. When the facility found this inconsistency, they immediately sent an email to DFPS. Probably, especially when situations such as this arise, there needs to be closer communication between DFPS and the IMC. Along these same lines, DFPS in response to the draft report, also noted that the investigator should have notified the facility upon discovering the existence of alleged perpetrators. It was good to see this similar perspective.

Outcome 5– Staff cooperate with investigations.

Summary: The facility met criteria for 100% of the investigations during this and also during the previous two reviews. Therefore, this indicator will move to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 95	93	570	474	222	225	69	446	
7	Facility staff cooperated with the investigation.	100% 10/10	1/1	1/1	3/3	1/1	1/1	1/1	1/1	1/1	

Comments:

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.

Summary: All three indicators improved from the last review, but need further improvement and continued focus from the IMC and the facility. For instance, all

Individuals:

staff identified as involved in an investigation need to be interviewed (or a rationale provided as to why not) and history, trends, prior occurrences, and severity of injury should play a role in reporting the injury for DFPS investigation. These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	95	93	570	474	222	225	69	446	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	70% 7/10	1/1	1/1	2/3	1/1	1/1	1/1	0/1	0/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	70% 7/10	1/1	1/1	2/3	1/1	1/1	1/1	0/1	0/1	
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	90% 9/10	1/1	1/1	3/3	1/1	1/1	1/1	0/1	1/1	

Comments:
8-9. For the three investigations that did not meet criteria, there was nothing to show that all staff involved were interviewed and, if so, what the content of the interviews were. All that was written was a sentence about reviewing the witness statements.

10. All but one of the investigations met criteria for this indicator, even for two of the investigations that did not meet criteria for indicators 8 and 9 because there was enough evidence to support the investigation conclusion.

For Individual #69 UIR 4173, however, the investigation conclusion was that cause could not be determined. Several plausible hypothesizes related to severe osteoporosis were presented in the UIR. However, because of his history of discovered injuries that were serious fractures, the facility investigation should have concluded with a plan to review the incidents in great detail to ensure that the facility had been doing everything one could possibly do to interrupt what seemed to be a pattern of frequent fractures.

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Investigations are, and have been commenced within 24 hours and completed within 10 calendar days (with one exception being completed in 11 days) for this review and the last two reviews. Therefore, indicators 11 and 12 will move to the category of requiring less oversight. Indicator 13 showed improvement from the last review, but more focus is required and it will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	93	570	474	222	225	69	446	
11	Commenced within 24 hours of being reported.	100%	1/1	1/1	3/3	1/1	1/1	1/1	1/1	1/1	

		10/10									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	90% 9/10	0/1	1/1	3/3	1/1	1/1	1/1	1/1	1/1	
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	70% 7/10	1/1	1/1	2/3	1/1	1/1	1/1	0/1	0/1	

Comments:
12. For Individual #95 UIR 4049, the investigation was completed on day 11; an extension request was not done/provided.

13. Supervisory review did not capture the problems with staff interviews for three investigations. Supervisory review, however, did capture problems with some of the late reporting occurrences, which was good to see. 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.

Additionally, as noted above, failure to accurately review and assess prior occurrences of discovered injuries, IPNs, and so forth were not identified in the facility review of Individual #69 UIR 4173.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.

Summary: Due to sustained high performance for indicator 14 over this review and the previous two reviews, this indicator will move to the category of requiring less oversight. The conduct of non-serious injury investigations also had high scores on this and the previous reviews, but there was a miss of a discovered injury for an individual with a history of serious injuries. Therefore, indicator 15 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	95	93	570	474	222	225	69	446	
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 8/8	1/1	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.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	

Comments:

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: Performance on these indicators has wavered over this and the last two reviews. Greater focus and attention to the requirements of these indicators may result in improved scores (and improved supports). These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	93	570	474	222	225	69	446	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	67% 6/9	1/1	1/1	2/3	1/1	1/1	0/1	0/1	N/A	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 4/4	1/1	N/A	1/1	1/1	1/1	N/A	N/A	N/A	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	75% 3/4	N/A	1/1	1/1	N/A	1/1	N/A	0/1	N/A	

Comments:
16. For Individual #570 UIR 4328 and for Individual #225 UIR 4315, the IMC reviews noted both of these as late reports, but there was nothing to describe any follow-up action to address the circumstances of the late report. The problems with the identification of the history of fractures for Individual #69 resulted in UIR 4173 also not meeting criteria for this indicator.

17. Four investigations recommended disciplinary actions, and it occurred as required. Four investigations recommended programmatic actions, and it occurred for three. For Individual #69 UIR 4173, recommendations in the ISPA on 2/5/16 did not occur.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. Criteria were met for some, but not for all five indicators. Details are provided in the comments below. These five indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan	No									

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

Comments:
21-23. Trend analysis and related QA activity did not identify serious trends. Moreover, the QAQI Council minutes did not contain any recommendations. Given the issues identified in this report, it was evident that the Abilene SSLC QA review process was not sufficiently robust.

For instance, in just this review period, there were a high number of fractures, especially discovered back and vertebrae fractures, as well other fractures, including forearm, tibia/leg, and fingers. Two more discovered fractures occurred during the onsite review week. One of these individuals had three significant fractures over a 13-month period. The investigation of the third fracture did not adequately review the individual's history of serious injuries and implementation of supports to reduce risks. Overall documentation in the individual's record did not support that the IDT had implemented and monitored supports to reduce risks, or that risks were even appropriately identified.

As written in the last monitoring report, 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.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: It was positive to see that proper procedures were followed for staff administered oral –pre-treatment sedation. During the previous two reviews, these indicators were not applicable. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	100% 3/3	N/A	N/A	N/A	2/2	N/A	N/A	N/A	N/A	1/1

Comments: a. Abilene SSLC had a Dental Policy Manual, dated 3/4/14, which included Policy 17.0, entitled "General Anesthesia and Oral

Sedation." This policy provided guidance as to which individuals would benefit from dental care under TIVA/general anesthesia. Although some dental criteria for TIVA were outlined, these often were not measurable criteria, and were not consistent with those included in the Dental Audit Tool [i.e., the following procedures must be anticipated: Deep Cleaning (D4341/D4342), Restorative (D2140-D2999), Endodontics (D3110-D3999), and Extractions (D7111-D7999). There are some procedures, such as pulling wisdom teeth or deep scaling that people in the community would expect some form of sedation. For other procedures, three failed attempts must occur first before TIVA is used. If the individual met this criterion before and has another dental need, then only one failed attempt would be necessary, utilizing any desensitization or other strategies developed for the individual. The dentist should describe in detail what issues were observed during the trials. The only exceptions to this would be emergencies. Even if there are failed attempts, teams should document discussion of the need for programmatic interventions to increase cooperation in the future.]. The Center should modify its policy to be consistent with these guidelines.

The Center's policy also only generally addressed the peri-operative evaluation. It stated: "All individuals who are selected to receive general anesthesia will have a pre-operative evaluation consisting of laboratory tests as deemed appropriate by the staff physician, a medical exam, a chest x-ray if indicated, an ECG (electrocardiograph) and be cleared for dental treatment under general anesthesia by the Medical Director or a physician acting in [sic] his behalf."

For the two instances of the use of TIVA reviewed, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and post-operative vital sign flow sheets were completed.

b. It was positive to see that proper procedures were followed for staff administered oral –pre-treatment sedation.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.

Summary: It was positive to see the Center continue to make progress with regard to following procedures when oral pre-treatment sedation was administered for medical treatment. The Monitoring Team will continue to assess this indicator.

Individuals:

#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	100% 3/3	N/A	1/1	N/A	N/A	N/A	1/1	N/A	1/1	N/A

Comments: None.

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

Summary: IDTs developed plans for all four individuals regarding PTCR. One was a formal plan, the others were more informal strategies. Although developed, they were not implemented or reviewed. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	93	2	222	225					
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	25% 1/4	0/1	0/1	1/1	0/1					
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	100% 4/4	1/1	1/1	1/1	1/1					
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	25% 1/4	1/1	0/1	0/1	0/1					
4	Action plans were implemented.	25% 1/4	1/1	0/1	0/1	0/1					
5	If implemented, progress was monitored.	100% 1/1	1/1	N/A	N/A	N/A					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1	0/1	N/A	N/A	N/A					

Comments:
1. The IDT addressed the required criteria for this indicator only for Individual #222. Specifically, while there was evidence of consent provided by the human rights officer, LAR/facility director consent was found only in the plan for Individual #222

2. A Medical Restraint Plan had been developed for all four of the individuals (Individual #93, Individual #2, Individual #222, Individual #225).

3. The plans described strategies and the possible reduction of future usage of PTCR and all were based upon the underlying hypothesized cause of the need for PTCR. Three of the four were not in the ISP or written in any documented format for implementation.

It was, however, concerning that aggression and self-injury were identified as observed behaviors when Individual #2 received exams/treatment. Neither behavior was addressed in her PBSP. Staff are advised to repeat a functional assessment to determine whether the PBSP should be revised to include these two behaviors.

3. A plan was developed for Individual #93. For the other three individuals (Individual #2, Individual #222, Individual #225), preventive guidelines were identified, but action plans were not developed.

4-6. A SAP was developed and implemented for Individual #93 to learn to cooperate with nursing staff during accu-checks. This was a positive response to a difficult situation. Data were recorded and reviewed monthly to assess progress. Although recommendations were provided due to lack of progress, it was not apparent that these had been implemented.

Other positive changes identified in Individual #93's MRP included a reduction in blood glucose testing from four times to once daily and the elimination of mechanical restraint in a wheelchair to ensure adequate nutrition.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	146	162	23	413	63	126	515	378	
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% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
e.	Recommendations are followed through to closure.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	

Comments: a. Since the last review, nine individuals died. The Monitoring Team reviewed eight deaths. The individuals who died included:

- On 12/7/15, Individual #146 died at the age of 43 with causes of death listed as chronic systolic heart failure, ischemic cardiomyopathy, and coronary artery disease;
- On 12/15/15, Individual #162 died at the age of 54 with causes of death listed as recurrent aspiration pneumonia, dysphagia, and cerebral palsy;

- On 2/13/16, Individual #23 died at the age of 68 with causes of death listed as aspiration pneumonia with pneumothorax, dysphagia, and severe intellectual disability;
- On 4/3/16, Individual #413 died at the age of 41 with causes of death listed as aspiration pneumonia, emesis from pancreatitis, and pancreatitis;
- On 5/27/16, Individual #63 died at the age of 68 with causes of death listed as septic shock, aspiration pneumonia, and non-ST segment elevation myocardial infarction (NSTEMI);
- On 6/2/16, Individual #126 died at the age of 41 with causes of death listed as epilepsy with status epilepticus, and Russell Silver syndrome;
- On 7/11/16, Individual #515 died at the age of 51 with causes of death listed as aspiration pneumonia, chronic aspiration, and dysphagia;
- On 7/25/16, Individual #378 died at the age of 41 with causes of death listed as pneumonia, and medical complications of cerebral palsy, complicated by hypotonic quadriparesis; and
- On 8/10/16, Individual #98 died with causes of death listed on the spreadsheet State Office regularly provides the Monitor as seizure due to Ganciclovir, and cerebral palsy. Because Individual #98's death occurred a couple of weeks before the onsite review, the Monitoring Team <u>did not conduct a review</u> due to the fact that it was too early for all of the documents to be available. In its comments, the State indicated the causes of death were "Sepsis due to candida and Severe intellectual disability." The State should correct one or more of the various documents that identify this individual's cause(s) of death.

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

- The RN Case Manager completed Nursing Death Reviews (which were not the same as the QA Nurse Mortality Review at Abilene SSLC), but these did not provide a meaningful review of care. They consisted of a one page "worksheet" that included the following questions: 1. What were the Nursing Protocols being followed? 2. Were chronic care plan and acute care plans appropriately managed? 3. Were Nursing Protocols follow up by nursing within last three months appropriately? 4. What were alternative Nursing interventions or supports services that would improve the overall care of the individual? 5. Are there any patterns or trends of concerns needing systems support? 6. What nursing changes are needed to prevent similar circumstances affecting other individuals? Although they varied in quality, the reviews often had one-sentence answers to these questions and no other information. These reviews revealed limited, if any, problems and/or recommendations. There was no indication that nursing staff conducted a complete and thorough review of these individuals' nursing care prior to their deaths. The recommendations noted from the other reviews (clinical and administrative) focused on the PCPs.
- In some cases, the QA nurse completed the Quality Assurance Death Review of Clinical Services that contained much more information regarding a review of the individual's care with some important findings. However, findings were not consistently translated into recommendations.

e. Although some progress was made in this regard, the recommendations generally were not written in a way that ensured that Center practice had improved. An example of improvement was a recommendation that read: "providers will be in-serviced [Medical Department staff] on Nissen fundoplication and the need for aggressive work up for individuals who demonstrate repeated unexplained emesis to be assessed for Nissen fundoplication or revision of an unraveled Nissen fundoplication by May 20, 2016. The Medical

Director will review all cases of repeat emesis admitted to the infirmary or hospital for a period of 30 days following the in-service to ensure compliance with the recommendations." Although 30 days was likely too short a period of time, the second component of the recommendation helped to determine whether or not practice changed as a result of the in-service training.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	ADRs are reported immediately.	N/A									
b.	Clinical follow-up action is completed, as necessary, with the individual.	N/A									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. Facility staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: Given that during the last review period and during this review, the Center completed clinically significant DUEs and followed up to closure on recommendations, if this performance is sustained during the next review, this Outcome likely will move to the category of requiring less oversight.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 6/6
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 5/5
Comments: a. and b. In the six months prior to the review, Abilene SSLC completed six DUEs, including: • In February 2016, a DUE on Prolia, which was discussed at the 5/19/16 Pharmacy and Therapeutics (P&T) Committee meeting, and closed during the August P&T Committee meeting; • A DUE on antibiotic use for urinary tract infections, which began on 2/17/16 and ended on 5/19/16, with no follow-up needed; • In April and May 2016, a DUE was completed on Lamictal, and in May 2016, a Lamotrigine Dosing Procedure was implemented;		

- A follow-up DUE on Tegretol (i.e., original study completed on 8/11/14, with follow-up studies in May 2015, August 2015, and February 2016), which was closed at the 2/17/16 P&T Committee meeting due to compliance with the parameters;
- A follow-up DUE in January 2016 on doxycycline for periodontitis (original in September 2015), which was closed at the 2/17/16 P&T Committee meeting due to compliance with the recommendations; and
- A follow-up DUE in January 2016 on Acetaminophen (i.e., original study in July 2015), which was closed at the 2/17/16 P&T Committee meeting due to compliance with the parameters.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Fifteen of these indicators, in psychiatry, behavioral health, medical, nursing, and skill acquisition, had sustained high performance scores and will be moved to the category of requiring less oversight. This included one entire outcome: Outcome #22 for Psychiatry.

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

IRRFs

For the individuals' risks reviewed, some limited improvement was seen with regard to IDTs effectively using supporting clinical data (including comparisons from year to year), using the risk guidelines when determining a risk level, and/or as appropriate, providing clinical justification for exceptions to the guidelines. However, for many individuals' risk areas, it remained unclear whether or not the risk ratings were accurate. Ongoing work is needed in this area. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

Assessments
Areas for focus regarding the ISP are ensuring that the proper IDT members attend the annual meeting and that proper assessments are prepared prior to the meeting. QIDPs were interviewed and found to be knowledgeable, to a degree, about some aspects of individuals' preferences and strengths, but were also often not able to articulate the status of various action plans and supports.

The Abilene SSLC lead psychiatrist was also the discipline lead for psychiatry statewide. Since the last review, he had met with the Monitoring Team a number of times and presented a set of examples of personal goals for four different psychiatric conditions. The Monitoring Team was very positive about these examples. If implemented, it would likely meet criteria for indicators 1 and 2 (and mostly likely for 3, too). Some progress in implementation occurred at Abilene SSLC for some individuals, but this new way of developing and presenting psychiatric personal goals was not implemented for all individuals and, moreover, implementation appeared to be hampered by the almost simultaneous and coincidental implementation of the statewide electronic health record. The Monitoring Team hopes that this can be worked out and that the format developed by the lead psychiatrist can be incorporated into the electronic health record.

That being said, a number of other psychiatry-related supports were in place, such as regarding comprehensive evaluations, annual psychiatry planning, and consent. Some of these indicators moved to the category of requiring less oversight.

Every individual reviewed who needed a PBSP had one and there were measurable goals, but good reliable data was collected only for two of the individuals. Functional assessments were current and, for the most part, complete. PBSPs were also current, but more work is needed regarding their completeness. Individuals who needed counseling were receiving it and proper documentation was maintained.

Skill acquisition plans existed and were measurable, however, much work is needed to ensure their relation to assessment, their meaningfulness, and the collection of reliable data, so that performance can be assessed.

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

Although some additional work was needed, the Center made progress with regard to the quality of medical assessments. For five of the nine individuals reviewed, the Medical Department assessed individuals' medical needs in accordance with generally accepted standards of care. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe childhood illnesses, and past medical histories, and include updated active problem lists, and plans of care for each active medical problem, when appropriate.

It was good to see that the Dental Department completed timely dental exams and summaries for all of the individuals reviewed. The Center also made progress on the quality of the dental exams and summaries. Dental Department staff should focus on maintaining/continuing to improve the quality of the exams and summaries, as well as maintaining timely completion of them.

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

The PNMT was not consistently providing needed reviews and/or assessments for individuals with physical and nutritional management-related needs that met criteria for referral to and/or review by the PNMT. In addition, when the PNMT completed assessments, they were not timely, and many issues were identified with regard to the quality of the assessments. For example, the PNMT had not consistently identified the etiology/cause of the problem, and the steps necessary to mitigate risk. Similarly, the analysis of the effectiveness of current supports often was not clear, making it unclear what, if anything, needed to change.

The PNMT often did not clearly define individualized clinical indicators to assist IDTs in identifying when the individual was healthy and/or when deterioration was potentially occurring. In addition, disciplines that should have been involved in the PNMT assessment were not. The Center should focus on ensuring that individuals who need PNMT involvement have it, and on improving the quality of the PNMT's reviews and assessments.

Minimal, if any, improvement was noted with regard to the timeliness or quality of OT/PT comprehensive assessments and updates. Of particular concern, was the significant deficits noted in relation to the OT/PT updates. They did not provide IDTs with the information needed to identify individuals' current strengths and needs, and develop plans to meet their needs while incorporating their preferences.

Center staff need to consistently conduct communication assessments timely, and most importantly, conduct assessments in accordance with individual's needs. In other words, it is important that individuals receive comprehensive communication assessments and/or updates at the frequency necessary to address their needs, including changes of status. In addition, Center staff need to focus on improving the quality of communication assessments.

Individualized Support Plans

ISPs did not yet have full sets of goals that were individualized and met the various criteria. Four ISPs, however, included some goals that met criteria, which was progress since the last review. Goals primarily focused on compliance issues and skill maintenance. There was little focus on opportunities to develop new skills and gain exposure to new experiences.

For the most part, ISP action plans did not support achievement of personal goals, incorporation of personal preferences, decision-making, independence, day programming/employment, or community integration. Most ISPs showed discussion of the preferences of individuals, their LARs, and their IDTs regarding community living. However, most did not show a thorough discussion of barriers to referral for transition and, without that discussion, there could be little planning to address any barriers.

In most cases, consistent implementation, progress, and/or regression of ISP goals and action plans could not be determined due to missing data. It was not evident that reviews resulted in action taken when ISPs were not implemented or not effective. QIDP monthly reviews were not comprehensive and did not review the status of all supports.

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.												
Summary: Abilene SSLC had recently completed training in the new ISP process. ISPs did not yet have full sets of goals that were individualized and met the criteria for this outcome. Four ISPs, however, included some goals that met criteria, which was progress since the last review. These three indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	474	2	570	225	452	297			
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	2/6	3/6	0/6	1/6	2/6			
2	The personal goals are measurable.	0% 0/6	0/6	2/6	3/6	0/6	1/6	2/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #474, Individual #2, Individual #570, Individual #225, Individual #452, and Individual #297. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Abilene SSLC campus.

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

Overall, outcomes remained very broadly stated and general in nature and/or were very limited in scope. No individuals had individualized goals in all ISP areas, resulting in a 0/6 overall score (the Monitoring Team, however, provided scores for each individual to show whether any of the six areas had a goal that met criterion). There were some goals that were individualized and based on preferences and strengths. These included:

- Individual #2's leisure goal to learn to use her remote control and her goal for greater independence to learn to dress herself.
- Individual #570's leisure goal to go swimming, his day programming goal to attend school for a total of six classes, and his living option goal to live at home with his parents.

- Individual #452's living option goal to live in a foster home.
- Individual #297's relationship goal to call his mother and his greater independence goal to use his remote control.

Review of ISPs and observation of IDT meetings indicated that, even so, staff were still struggling with developing a set of individualized meaningful measurable goals for all individuals. Additionally, goals primarily focused on compliance issues and skill maintenance. There was little focus on opportunities to develop new skills and gain exposure to new experiences. Examples that did not meet criterion were:

- Individual #225's leisure goal to be given the opportunity to attend activities focused on his preferences and his relationship goal to maintain his current relationships.
- Individual #452's day programming goal to attend the activity center at least 25% of her scheduled sessions.
- Individual #297's day programming goal to improve his attendance by 10%.

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

Six of the eight goals listed above that met criterion for indicator 1 were also considered to be measurable goals. The two exceptions were Individual #297's relationship and greater independence goals.

The Monitoring Team acknowledges that the development of personal goals that will meet criteria is a work in progress at all facilities. More guidance is expected from state office. Moreover, the QIDP coordinator and the QIDP educator will be very important in supporting teams to make goals that meet criterion for compliance. To do so, they will need to provide a lot of feedback to the QIDPs and to other team members.

3. In most cases, personal goals were not individualized or measurable, so there was no basis for assessing whether reliable and valid data were available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals.

For the goals that did meet criterion, there was not reliable and valid data on implementation of the plans to address the goals. Review of data implementation sheets, ISP preparation documentation, and QIDP monthly reviews showed that consistent data were not collected for most ISP action plans. Many goals were not implemented with the frequency required, or in some cases, never implemented.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met, but in a handful of cases. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	474	2	570	225	452	297			

8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	1/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/5	0/1	0/1	N/A	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	2/6	0/6	0/6	0/6	0/6	1/6			

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. Of the handful of personal goals that were individualized and measurable, two (Individual #2's greater independence goal, Individual #297's relationship goal) had action plans that would support achievement of his goal.

For the most part, personal goals did not meet criterion in the ISPs as described above in indicator 1. Therefore, action plans cannot be evaluated in this context. A personal goal that meets criterion is a pre-requisite for such an evaluation. Action plans are evaluated below in terms of how they may address other requirements of the ISP process.

9. Preferences and opportunities for choice were not well integrated in the individuals' ISPs.

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

11. Overall, action plans did not assertively promote enhanced independence for any of the individuals. Individual #2 and Individual #297 had goals that minimally addressed their enhanced independence.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans. Examples included:

- Individual #474's ISP did not integrate strategies to address weight and cardiac issues.
- Individual #2's aspiration risk had not been adequately assessed by the PNMT. Her positioning plans were not data driven and recommendations were not clearly stated.
- Individual #570's IDT developed a living option goal to live with his mother, however, the IDT did not address related risks. He had been removed from his family home prior to placement at Abilene SSLC.
- Individual #225's recent diagnosis of dementia had not been adequately assessed prior to his ISP meeting. He had also been the victim of peer-to-peer aggression numerous times over the past year. His ISP did not address his risks related to peer-to-peer aggression.

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. All individuals had complex needs that would benefit from integrated supports.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were minimal specific plans for community participation that would have promoted any meaningful integration for any individual. For Individual #452, the ISP included trips in the community based on her preferences that might have led to successful integration (e.g., visits to the beauty shop and library in the community), however, without clear implementation strategies, it was not likely that integration would occur.

15. Only one of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #570 had a goal for full day attendance at the local high school.

- Individual #474 was scheduled to attend high school in the community for a half day. The IDT had not considered other opportunities for him to become more integrated in his community by participating in after school activities, exploring jobs, membership at the local gym, etc.
- Individual #452 and Individual #297's ISP indicated that they were rarely involved in programming off of the home. Both IDTs acknowledged that staffing issues contributed to poor attendance at day programs. The IDT did not address barriers to participating in off home activities.
- Staff reported that Individual #225's work attendance had declined due to his recent change in functional status. The IDT developed an attendance goal for him without considering that his vocational preferences and support needs may need to be updated or revised to reflect his current status.
- Individual #2 often refused work. Her ISP did not document discussion of opportunities for employment based on her

preferences and strengths in a more integrated setting.

16. None of the individuals had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs.

17. Barriers to various outcomes were not consistently identified and addressed in the ISP.

- Individual #474's SAP for pedestrian safety, weight loss, and other outcomes were continued from the previous ISP without discussion of the barriers to progress.
- Individual #2's ISP noted that she rarely attended the day program. Barriers to attendance were not addressed.
- Individual #225's IDT attributed his lack of progress to his recent dementia diagnosis. His changing support needs were not identified or addressed in his ISP.
- As noted above, staffing issues were identified as a barrier to program attendance for Individual #452 and Individual #297. Neither IDT addressed this barrier.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were rarely measurable or did not provide a clear path to accomplishing goals. Living options action plans generally had no measurable outcomes related to awareness and no criteria for completion or frequency. For example, Individual #225's living option goal stated that he would be offered the opportunity for a tour of community options.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.												
Summary: Criterion was met for some indicators for some individuals, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. A primary area of focus is the identification actions to address obstacles to referral. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	474	2	570	225	452	297				
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1				
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	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	1/1	1/1	0/1				
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	67% 4/6	0/1	1/1	0/1	1/1	1/1	1/1				

#	Indicator	Overall Score									
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	50% 3/6	0/1	0/1	1/1	0/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	N/A	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	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.	20% 1/5	0/1	N/A	0/1	1/1	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. Five of six ISPs included a description of the individual's preference and how that was determined. Individual #2's ISP noted that her preferences were unknown.

21. Five of six ISPs fully included the opinions and recommendation of the IDT's staff members. Individual #297's ISP noted that medical issues were a barrier to referral, however, his medical assessment stated that he could receive supports in the community.

22. Four of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Those that did not accurately reflect the basis for the decision were the following:

- Individual #474's ISP did not include a summary statement of the IDT's recommendation.
- Individual #570's ISP did not describe how input from his LAR was obtained since she did not attend the IDT meeting.

23. Five of six ISPs did not include documentation of a thorough discussion regarding other options that may be available based on their preferences and support needs. Individual #452's ISP included a discussion of her preferences in relation to living options.

24. All ISPs had a completed checklist of barriers to community placement. This was good to see, however, it would be beneficial for planning if the ISP included more detail regarding barriers. For example, some ISPs noted behavior or medical issues that precluded consideration of a referral. In some cases, it was not clear what the specific behavior or medical issue was that could not be supported in the community.

- Individual #474's IDT agreed that he could be referred to the community, though it was not clear if he was referred.

- Individual #2's living option discussion indicated that the team identified behavioral and medical issues that were barriers to referral. Her checklist of barriers only noted LAR decision.
- Individual #225's ISP narrative indicated that his family's wishes might be a barrier to referral, however, the barrier checklist did not include this.

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

28. Only one individual (Individual #452) had individualized, measurable action plans to educate the individual and /or LAR on community living options.

29. All individuals had obstacles identified at the time of the ISP.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISPs were developed in a timely manner, but not implemented in a timely manner. Not all individuals participated in their ISP preparation and annual meetings, and not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	474	2	570	225	452	297			
30	The ISP was revised at least annually.	100% 5/5	1/1	1/1	N/A	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	N/A	1/1	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).	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			

Comments:
30-31. All ISPs were developed on a timely basis.

32. The Monitoring Team was unable to confirm that all action plans and supports included in the ISP were implemented within 30 days for any individual. For example,

- QIDP monthly reviews indicated that Individual #225's money management SAP was not implemented within 30 days.

- Individual #452 had not been to the library or beauty salon.
- Individual #297's March 2016 monthly review indicated that the previous year's ISP was still being implemented in February 2016. Her new ISP should have been implemented by 1/10/16.

33. Only two of six individuals (Individual #2, Individual #297) attended their ISP meetings. Individual #570's ISP meeting was scheduled when he was at school and Individual #474's at the same time as an eye appointment. There was no evidence that the IDT attempted to schedule the meeting when they could attend.

34. Only one individual (Individual #474) had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples of those that did not met criteria included:

- No attendance by the PCP at Individual #2, Individual #452, and Individual #297's annual meeting.
- No participation by a DSP at Individual #570's meeting.
- No participation by a DSP, behavioral health specialist, or psychiatrist at Individual #225's meeting.

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

Summary: Assessments that were needed were considered and identified by the IDTs for four of the six individuals. For all individuals, assessments were not always obtained prior to the ISP meeting. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 474	2	570	225	452	297			
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	1/1	0/1			
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 three individuals. Individual #570 was recently admitted, so did not have an ISP preparation meeting. The team did, however, arrange to have a number of relevant assessments completed prior to his initial ISP meeting.

Individual #225's team did not consider an assessment to determine the status of his dementia. Individual #297's IDT did not consider an updated OT/PT assessment prior to developing goals for the use of adaptive equipment.

36. IDTs did not arrange for and obtain needed, relevant assessments prior to the IDT meeting for five individuals. Late or missing assessments included:

- For Individual #474: Medical
- For Individual #570: Dental, Behavioral Health Assessment, FSA, and nursing.
- For Individual #225: Medical
- For Individual #452: FSA and Medical
- For Individual #297: Behavioral Health Assessment

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.												
Summary: IDT and QIDP reviews were not occurring regularly, were not based on data, and did not result in actions when needed. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	474	2	570	225	452	297				
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				

Comments:

37. IDTs 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, experienced regression, or refused to participate. For example:

- For Individual #2, monthly reviews indicated that work attendance remained low (two days in February, two days in March, six days in April). The team did not meet to revise her plan or address any barriers to implementation.
- Individual #225 was involved in at least 15 peer-to-peer aggression incidents from March 2016 to June 2016. The team did not meet to discuss these incidents or ensure protections were in place for his safety.

38. QIDPs did not ensure that the individual received required monitoring/review and revision of treatments, services, and supports. QIDPs were interviewed and found to be knowledgeable, to a degree, about some aspects of individuals' preferences and strengths, but were also often not able to articulate the status of various action plans and supports. In most cases, consistent implementation, progress, and/or regression could not be determined due to missing data. It was not evident that reviews resulted in action taken when ISPs were not implemented or not effective. QIDP monthly reviews were not comprehensive and did not review the status of all supports. For example,

- The QIDP monthly review noted that Individual #225 had a number of new assessments completed over the past several months related to his regression in functional status, however, the IDT failed to review the assessments and incorporate any new recommendations into his ISP. He had shown a lack of progress towards meeting his goals and some action plans had not

	been implemented. The IDT did not meet to revise his plan. • Individual #297's QIDP monthly reviews indicated that his SAP for dialing the phone was not implemented in May 2016 or June 2016 and only implemented twice in March 2016 and April 2016. His SAP to learn to use his remote control was not implemented in March, April, or June 2016 and only implemented one time in May 2016. The QIDP did not follow-up on lack of implementation.

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	The individual's risk rating is accurate.	33% 6/18	0/2	1/2	0/2	2/2	1/2	1/2	1/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #474 – weight, and behavioral health; Individual #2 – falls, and respiratory compromise; Individual #297 – respiratory compromise, and polypharmacy/side effects; Individual #242 – dental, and weight; Individual #452 – hypothermia, and weight; Individual #182 – dental, and behavioral health; Individual #515 – urinary tract infections (UTIs), and cardiac disease; Individual #503 – constipation/bowel obstruction, and weight; and Individual #92 – cardiac disease, and dental]. a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #2 – respiratory compromise; Individual #242 – dental, and weight; Individual #452 – hypothermia; Individual #182 – dental, and Individual #515 – cardiac disease. 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. Individual #2 did not have changes in status documented with regard to respiratory compromise.											

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: The Abilene SSLC lead psychiatrist was also the discipline lead for psychiatry statewide. As noted below, since the last review, he had met with the Monitoring Team a number of times and presented a set of examples of personal goals for four different psychiatric conditions. The Monitoring Team was very positive about these examples. If implemented, it would likely meet criteria for indicators 1 and 2 (and mostly likely for 3, too). Some progress in implementation occurred at Abilene SSLC for some individuals, but this new way of developing and presenting psychiatric personal goals was not implemented for all individuals and, moreover, implementation appeared to be hampered by the almost simultaneous and coincidental implementation of the statewide electronic health record. The Monitoring Team hopes that this can be worked out and that the format developed by the lead psychiatrist can be incorporated into the electronic health record. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
4	The individual has goals/objectives related to psychiatric status.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
5	The psychiatric goals/objectives are measurable.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
6	The goals/objectives are based upon the individual's assessment.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A

Comments:
4-7. Psychiatry continued to make progress towards the development of individualized personal goals based upon the individual's psychiatric condition, and that included using specific measures, which have come to be called psychiatric indicators. The development of personal goals/objectives that would meet the criteria for these indicators was discussed with the facility's lead psychiatrist in the interim since the prior onsite review. These discussions included in-person and phone-call meetings between the lead psychiatrist and the Monitoring Team during which the lead psychiatrist presented a set of examples of goals related to, and derived from, the individual's psychiatric diagnosis. These examples were presented in a one-page format with lots of relevant information. These demonstrated significant progress in the development of personal goals that identified the specific linkage between the psychiatric indicators and the symptoms of the underlying psychiatric disorder.

Implementation, however, was hampered by the implementation of electronic record (IRIS). It will likely take some time for this to be solved and worked out. The Monitoring Team hopes that the format presented by the lead psychiatrist to the Monitoring Team over the past few months can somehow be incorporated into IRIS. The most recent psychiatric quarterly, PTP and IRRF for Individual #474 were completed in the new electronic format. This documentation focused on the psychiatric indicators as the starting point for psychiatric documentation rather than the psychiatric diagnosis and the related symptoms of the disorder from which the psychiatric indicators were presumably derived. The psychiatric indicators were primarily the target behaviors for which the psychotropic medications were prescribed, such as aggression and self-injury. The documentation did contain grids that indicated the derivation of the psychiatric indicators, but this linkage was no more specific than a general statement that the behavior was either derived from the psychiatric aspects of the individual's presentation, the behavioral contributions, or a combination of both. These general statements about efficacy did not specify the linkage of the target behavior/psychiatric indicator to the symptoms of the underlying psychiatric disorder in a manner that would facilitate the development of goals that were related to the progress in treating the underlying psychiatric disorder. As noted above and to reiterate, the examples that the lead psychiatrist presented to the Monitoring Team prior to the implementation of the electronic record demonstrated good progress and may have resulted in meeting criteria for one or more of the indicators in this outcome.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: CPEs were done for all but one individual. They were in the required format and contained the required content. Indicators 13 and 14 will be moved to the category of requiring less oversight. With sustained performance, indicator 12 might move to the category of requiring less oversight after the next review. Indicators 15 and 16 will require focused attention. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
12	The individual has a CPE.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
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	1/1	N/A
14	CPE content is comprehensive.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	N/A
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.	50% 2/4	N/A	N/A	1/1	0/1	N/A	0/1	1/1	N/A	N/A

16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	38% 3/8	0/1	1/1	0/1	1/1	0/1	0/1	1/1	0/1	N/A

Comments:
12-13. All of the individuals had a CPE that was formatted as specified and contained the required information, with the exception of Individual #225. Individual #225 was evaluated with a Reiss screen on 12/17/15 for a significant change in status. The score was 25, which was significantly above the clinical cut off score leading to a recommendation for a psychiatric evaluation. This was responded to with a brief psychiatric consultation that discussed the possibility of dementia. A CPE was not performed and the related provision of the Settlement Agreement was clear in noting that a REISS screen with a significantly elevated score should be responded to with a CPE performed in a timely manner.

14. The CPEs were thorough documents with all of the required information for all individuals, except Individual #2. Her CPE's physical exam was a brief review and did not fully discuss findings, and the biopsychosocial summary did not meet criteria. It was completed in 2011, before the facility made improvements to its CPEs. The facility should consider updating CPEs done prior to mid-2012.

15. Four individuals were admitted after 1/1/14 (Individual #93, Individual #570, Individual #554, Individual #474). Individual #93 and Individual #474 had both the required IPN note as well as the CPE. The documentation for Individual #554 contained the required CPE, but did not have an IPN within the required time frame. The record for Individual #570 did not meet either of these requirements because the IPN did not occur on a timely basis and the psychiatry department relied on the CPE from another facility that had been performed the month prior to admission and, thus, did not repeat one after his admission as required by this provision.

16. The psychiatric diagnosis was consistent in the psychiatric, behavioral and medical sections of the record for three of the eight individuals for whom this was relevant. The diagnoses were discordant in both the behavioral and medical sections for Individual #95, Individual #93, and Individual #554. The diagnoses were concordant in the psychiatric and behavioral sections, but not the medical section for Individual #2 and Individual #222. It was noted that, for some individuals, the annual medical assessment had begun to simply refer the reader to the psychiatric section for the diagnosis rather than listing them. This was found to be unacceptable unless they also listed the diagnoses they were aware of. This issue was discussed with the lead psychiatrist during the onsite review and he indicated that the new electronic record system should automatically populate the diagnoses consistently throughout the record.

Outcome 5 – Individuals' status and treatment are reviewed annually.	
Summary: Psychiatric treatment documentation was updated within the past 12 months and documentation was submitted to the IDT on time. These two indicators had been occurring at Abilene SSLC for some time and, therefore, these indicators (17, 19) will move to the category of requiring less oversight. Indicators 20 and 21 showed great improvement since the last review and if sustained might move to the category of requiring less oversight after the next review. The facility should ensure	Individuals:

that newly admitted individuals have documentation prepared for their new ISP meetings (indicator 18). These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
17	Status and treatment document was updated within past 12 months.	100% 7/7	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	N/A
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	N/A
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A

Comments:

18-19. As noted in the CPE section in outcome 4, Individual #570 had a CPE dated 12/14/15 when he resided at another facility. The psychiatry department at Abilene SSLC utilized this as the annual update submitted to the ISP team for his annual ISP on 1/14/16. Although this met the timelines required by indicator 19, it did not contain any information concerning his reaction to this significant environmental change, nor was it able to convey any information about the high frequency of behavioral disruption that he was displaying in his new environment. It was for those reasons that it was considered inadequate for indicator 18.

20-21. The psychiatric provider attended the ISP for each of the individuals. The psychiatric documentation for each of these individuals referenced the role of the psychiatrist in leading the discussion of the psychiatric aspects of the behavioral health review and the content of the IRRFs covered the required information. The Monitoring Team attended the ISP for Individual #93 to observe the participation of the psychiatric provider and assess the content of the material presented. The psychiatric provider led this section of the ISP and was also active at other points in the discussion.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
Summary: Abilene SSLC did not utilize PSPs and has not over the course of the previous two reviews, too. Therefore, this indicator will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: 22. None of the individuals had a PSP and the facility did not routinely utilize them.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: Consent-related activities for psychiatric services met criteria for all five indicators for all individuals. This was a great improvement from the last review. With sustained performance, these indicators might move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
30	A risk versus benefit discussion is in the consent documentation.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
32	HRC review was obtained prior to implementation and annually.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
Comments: 28-32. The consents for-psychotropic medications were obtained on an annual basis as required as well as the review and approval by the HRC. The documentation supplied to the guardians was complete and understandable. There were references to alternate non-pharmacological interventions in the information supplied to the LAR. In those situations where the consent for a new medication was obtained by the psychiatrist via a telephone call, the completed signed documentation was returned to the facility in a timely manner.											

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.	
Summary: Abilene SSLC ensured that every individual who needed a PBSP had a PBSP and that the PBSPs had goals/objectives as per criteria and that goals/objectives were measurable. This had been the case at the facility for a number of consecutive reviews and, therefore, indicators 1, 2, and 3 will move to the category of requiring less oversight. More work will need to be done for indicators 4 and 5 to also move to this category. Indicator 5 showed some progress since the last two reviews. The Monitoring Team hopes that the facility can build on	Individuals:

#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
	this. These two indicators will remain in active monitoring.										
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.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, 11 required a PBSP. All nine of the individuals reviewed by the behavioral health monitoring team needed, and all had, PBSPs. Of the six other individuals reviewed by the physical health monitoring team, two (Individual #242, Individual #182) needed, and had, PBSPs. Observation by the Monitoring Team and discussion with facility staff suggested that all of those who needed PBSPs had them in place.

2. The nine individuals reviewed by the behavioral health monitoring team had goals related to behavioral health services. This included goals for problem behaviors, replacement and/or alternative behaviors, and counseling needs.

3. All of the behavioral goals were measurable.

4. For seven of nine individuals, the goals were based upon their functional assessments. One exception was Individual #93, for whom medication and meal refusals had been identified as problem behaviors. These were deleted as targeted behaviors in her PBSP, with the former monitored by nursing staff and the latter measured through food consumption. Because both of these behaviors had resulted in high rates of restraint in the past, staff are encouraged to include these in her PBSP, and there should be consistency in what is in the functional assessment and what is in the PBSP. The other exception was Individual #225. His functional assessment identified verbal hostility, but his PBSP included additional behaviors of threatening and aggression.

5. The Monitoring Team determined that the data for two of the individuals (Individual #93, Individual #222) were reliable. This determination was based on the documents that noted monitoring of data timeliness and IOA over a six-month period. Following the

implementation of an electronic data system, onsite determination of data timeliness was not possible. The director of behavioral services continued to work on establishing a system to ensure that acceptable measures were established and achieved.

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

Summary: All three indicators showed improvement compared to the previous review. An area of focus for the facility is the content and completeness of the behavioral health update. This information can be very important to the treating behavioral health specialist, psychiatrist, and other members of the IDT. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 95	530	93	570	2	554	474	222	225
10	The individual has a current, and complete annual behavioral health update.	22% 2/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	78% 7/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

10. Although all of the individuals had a current behavioral health assessment, only two were considered complete (Individual #570, Individual #2). For the other seven individuals, problems included the following: absence of information regarding the individual's medical/physical health over the past 12 months (Individual #95, Individual #530, Individual #554, Individual #474, Individual #222), incomplete information regarding an adaptive behavior assessment (Individual #95) or the individual's preferences and strengths (Individual #530, Individual #225), or no follow-up regarding the introduction of PECS materials (Individual #93). Individual #554's report noted that he was being admitted, though it was dated 10 months after his admission date. Finally, Individual #225's assessment noted that he was displaying increased aggression, agitation, and anxiety, but there was no recommendation to complete a functional assessment.

11. All of the nine individuals had a current functional assessment at the time of the document request. Individual #474's was completed in August 2015; a new assessment should have been completed during the Monitoring Team's visit.

12. Seven of the functional assessments were considered complete (Individual #95, Individual #570, Individual #2, Individual #554, Individual #474, Individual #222, Individual #225). Each contained indirect and descriptive assessments completed within the past 12 months. Staff are advised to revise the report date when assessments are completed after the date of the initial report (e.g., Individual #225's report was dated 9/29/15, but included reviews of assessments completed between 10/2/15 and 10/29/15). These assessments would be enhanced if more frequent direct observations were described and reviewed.

The two functional assessments determined to be incomplete referenced indirect assessments that were completed in 2013 (Individual

#530) or 2014 (Individual #93).

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: PBSPs at Abilene SSLC were current and had been for some time. Therefore, indicator 14 will move to the category of requiring less oversight. The facility should ensure PBSP implementation within the 14-day requirement. PBSPs were, for the most part, complete, but did not yet meet the criteria. Moreover, two aspects of programming at Abilene SSLC require particularly close oversight. The Monitoring Team provides a number of considerations below. These are regarding the use of exclusionary time out (for one individual) and a respite home (for eight individuals). Indicators 13 and 15 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	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:
13. Six of nine PBSPs were implemented within 14 days of required consents. The exceptions were Individual #554, Individual #474, and Individual #225.

14. The PBSP for all nine individuals was current within the past 12 months.

15. Although none of the PBSPs were complete, the majority of components were evident. In only three of the nine PBSPs (Individual #93, Individual #2, and Individual #222), were there sufficient opportunities identified for the individual to practice her replacement/alternative behavior(s). While some plans included excellent reinforcement strategies (e.g., the token system in place for Individual #570, Individual #554, and Individual #474), other plans continued to lack sufficient use of positive reinforcement (Individual #95, Individual #2, Individual #225).

Specific comments are provided below regarding plans that included exclusionary time out and/or use of a respite home.

Exclusionary time out was introduced with one individual, Individual #570. While the long-term goal was to teach him to remove himself from stressful or uncomfortable situations, there are some changes that are recommended to the current protocol.

- The individual cannot be observed via camera. Staff must be able to directly see the individual at all times.
- The plan should be revised to indicate that time out must be terminated should the individual break a window, begin to engage

in serious self-injury, or otherwise put him/herself at risk of harm.

- Although the director of behavioral services reported that this intervention could not be used unless a behavior coach was present, this was not specified in either the PBSP or CIP. These plans should be revised to include this requirement.
- The form used to document time out should include start and stop times. Furthermore, the behavior observed during time out should be defined in observable and measurable terms. Labels should not be used because these do not clearly describe the individual's behavior.
- There should be a protocol for ongoing supervision from a clinical supervisor.
- The use of exclusionary time out should be reviewed at the monthly meeting of the Behavior Support Committee, as well as periodically by external peer review.
- The use of exclusionary time out should be reviewed at the Human Rights Committee and other forums where facility management (e.g., facility director, ADOP) can be kept apprised of its usage, such as at the restraint reduction committee or QAQI Council.

At the time of the last Monitoring Team review, a respite home program was initiated and being used for one individual. Over the last six months, eight individuals had been sent to the respite home. Three of these individuals (Individual #95, Individual #570, Individual #225) were reviewed during this visit. Provided below are comments and feedback regarding the current policy and practice.

- If Abilene SSLC is supporting individuals with more intense behaviors, and there is such a strong need for the respite home (i.e., used by eight individuals in six months), then Abilene SSLC should consider developing alternatives for the long-term, such as smaller settings than what is currently available on campus. The smallest residential setting was for six individuals. However, if some individuals do not do well with even these smaller numbers and community alternatives are not available, then consideration should be given to developing apartment settings, where only a couple of people live together.
- Analysis should be done to determine whether or not there are other factors that need to change to reduce the need for the use of respite (e.g., staffing, training, adherence to PBSPs, changes to PBSPs).
- Given the restrictiveness of this procedure, a more intense level of review should occur, such as what is used when an individual has more than three restraints in 30 days.
- The policy indicates that "Typically, respite services are initiated when peers at the person's home have indicated fear of the person." While maintaining safety is a priority, this opens an opportunity for individuals to retaliate against others. Alternative steps may include an increase in supervision for the reporter, a reassignment to another home, etc.
- Respite should be used only when less restrictive strategies have not been effective and should not be used in lieu of adequate treatment, including appropriate programming.
- It was also noted that "Respite may be initiated on an emergency basis when very dangerous behavior is exhibited whether to self or others." Specific steps for determining an emergency and initiating respite should be delineated in the policy.
- Prior to placement in respite, the team is supposed to complete the IDT Consideration of Need for Respite Services. Documentation of this determination must be maintained and reviewed.
- Only the director of behavioral services or the clinical supervisor (of behavioral health services) can approve the use of respite services.
- In some cases, it was noted that SAP training was suspended. Placement in respite should not result in an interruption in programming, including SAPs.
- For any individual placed in respite, there should be regularly scheduled opportunities for the individual to leave the building.

- Documentation of spending time out of the home should be maintained. This should include the duration and identified activity (e.g., walk, work, appointment).
- The use of respite should never be used as a threat. If an individual expresses an unwillingness to return to respite, staff should discuss positive behaviors that he/she exhibits and that will maintain his/her current placement.
- There should be specific criteria that would result in a review and possible revision of the individual's daily schedule, PBSP, and CIP. An update FBA should be initiated.
- The Monitoring Team learned that staff training does not necessarily occur when an individual is receiving respite services. Further, there is no indication that treatment integrity or data reliability are assessed while the individual is in respite. These should be addressed in the policy.
- For those individuals who have this outlined in their CIPs, the criterion for terminating respite services was 24 hours without problem behavior. One individual (Individual #446) was placed in respite for three days following an aggressive incident on the school bus. It was unclear why this was the response when this behavior is likely targeted in his PBSP.
- Supervision responsibilities are not clearly identified. The policy notes that any individual in respite must receive at least one to one staff support. It is unclear if the staff member receives ongoing supervision from the home manager or from behavioral health services staff. It is also recommended that at least two staff be present.
- There is no policy for ongoing supervision and clinical oversight by the behavioral health services director or an identified alternate. It is suggested that regular contact (e.g., once every hour between 8:00 am and 8:00 pm) be maintained. Thereafter, the on campus supervisor would be contacted.
- The use of respite services should be reviewed at the monthly meeting of the Behavior Support Committee, as well as periodically by external peer review.
- The use of respite services should be reviewed at the Human Rights Committee meeting and other forums where facility management (e.g., facility director, ADOP) can be kept apprised of its usage, such as at the restraint reduction committee or QAQI Council.
- Data collected during an individual's stay in respite should be reviewed daily by the director of behavioral health services or his alternate.
- It is positive that the offices of behavioral health services have been relocated to the adjoining wing of the building used for respite. This allows for ongoing supervision during normal working hours.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: Counseling has been provided when needed for individuals during this review and the previous two reviews. Therefore, indicator 24 will move to the category of requiring less oversight. Treatment plans and progress notes were available for this review and with sustained performance, indicator 25 might also move to the category of requiring less oversight. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 3/3	1/1	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A

25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 3/3	1/1	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A

Comments:
24. Counseling services were being offered for three individuals (Individual #95, Individual #570, Individual #474). Services were just being re-introduced for Individual #570, who had recently returned from a hospitalization.

25. A review of documentation, revealed complete counseling plans and data-based review of progress.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.

Summary: It was good to see improvement with regard to the timely completion of medical assessments (Round 9 – 78%, Round 10 – 56%, and Round 11 - 89%). Indicator c will be assessed once the ISPs reviewed integrate the revised periodic assessment process.

#	Indicator	Overall Score	Individuals: 474	2	297	242	452	182	515	503	92
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	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.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	0/1	N/A	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	N/R									

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

Outcome 3 – Individuals receive quality routine medical assessments and care.

Summary: Although some additional work was needed, the Center continued to make progress with regard to the quality of medical assessments. Given that over the last two review periods and during this review, individuals reviewed had diagnoses justified by appropriate criteria (Round 9 – 100% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11 -100% for Indicator 3.b), Indicator b will move to the category of requiring less oversight. The remaining indicator for this Outcome will be assessed once the ISPs reviewed integrate the

Individuals:

revised periodic assessment process.											
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	Individual receives quality AMA.	56% 5/9	1/1	0/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1
b.	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
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

Comments: a. It was positive that the AMAs for five individuals reviewed included all of the necessary components to identify and address individuals' medical needs. Problems varied across the remaining medical assessments the Monitoring Team reviewed. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe childhood illnesses, and past medical histories, and include updated active problem lists, and plans of care for each active medical problem, when appropriate.

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

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

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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.	17% 3/18	1/2	0/2	1/2	0/2	0/2	0/2	1/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #474 – cardiac disease, and weight; Individual #2 – respiratory compromise, and constipation/bowel obstruction; Individual #297 – aspiration, and osteoporosis; Individual #242 – gastrointestinal (GI) problems, and weight; Individual #452 – respiratory compromise, and other: hypothyroidism, and hypothermia; Individual #182 – GI problems, and osteoporosis; Individual #515 –

aspiration, and UTIs; Individual #503 – GI problems, and cardiac disease; and Individual #92 – aspiration, and weight].

The ISPs/IHCPs that sufficiently addressed the individuals' chronic or at-risk conditions in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations were those for: Individual #474 – cardiac disease, Individual #297 – osteoporosis, and Individual #515 – aspiration, and UTIs.

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

Dental

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

Summary: It was good to see improvement from the last review in terms of timeliness of dental exams for the individuals reviewed. For this review and the last review, dental summaries were completed on time, but during the Round 9 review, due to issues with documents, the Monitoring Team was not able to assess the timeliness of dental summaries. If the Center continues to complete dental exams and summaries in a timely manner, during the next review, these indicators will likely move to the category requiring less oversight. It was also good to see progress related to the quality of dental exams and summaries.

#	Indicator	Overall Score	Individuals: 474	2	297	242	452	182	515	503	92
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	100% 1/1	N/A	N/A	N/R	N/A	N/R	N/A	N/A	1/1	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 6/6	1/1	1/1		1/1		1/1	1/1	N/A	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 7/7	1/1	1/1		1/1		1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	67% 6/9	1/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	0% 0/7	0/1	0/1	N/R	0/1	N/R	0/1	0/1	0/1	0/1

Comments: For Individual #297, and Individual #452, who were in the outcome group and were at low risk for dental, some indicators were not assessed.

b. It was good to see that the dental exams of six individuals the Monitoring Team reviewed (i.e., Individual #474, Individual #2 - edentulous, Individual #242, Individual #515 - edentulous, Individual #503 - edentulous, and Individual #92) contained all of the necessary components. On a positive note, all dental exams reviewed included, as applicable, a description of the individual's cooperation, an oral cancer screening, an oral hygiene rating completed prior to treatment, a description of sedation use, periodontal charting, a description of periodontal condition, an odontogram, a summary of the number of teeth present/missing, specific treatment provided, the recall frequency, and a treatment plan. Most included information regarding the last x-ray(s) and type of x-ray, including the date. However, staff in the Dental Department should focus on ensuring exams include, caries risk, and periodontal risk.

c. It was positive that all of the dental summaries reviewed included the following, as applicable:

- Recommendations related to the need for desensitization or other plan;
- A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret;
- Effectiveness of pre-treatment sedation;
- Provision of written oral hygiene instructions;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations; and
- A description of the treatment provided.

Most included:

- An individualized treatment plan, including the recall frequency.

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

- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely comprehensive nursing assessments (Round 9 – 89%, Round 10 – 78%, and Round 11 -100%), Indicators a.i. and a.ii. will move to the category of requiring less oversight. Although since the last review, improvement was also seen with regard to the timeliness of the completion of quarterly nursing record reviews, the remaining indicators will continue under active oversight. The Center should focus on the completion of quality nursing assessments for the annual ISPs, and when individuals experience changes of status, the completion of assessments in accordance with current standards of practice.			Individuals:								
#	Indicator	Overall	474	2	297	242	452	182	515	503	92

		Score									
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that for the nine individuals reviewed, nursing staff completed timely annual comprehensive nursing reviews and physical assessments, and quarterly nursing record reviews and physical assessments.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #474 – weight, and behavioral health; Individual #2 – falls, and respiratory compromise; Individual #297 – respiratory compromise, and polypharmacy/side effects; Individual #242 – dental, and weight; Individual #452 – hypothermia, and weight; Individual #182 – dental, and behavioral health; Individual #515 – UTIs, and cardiac disease; Individual #503 – constipation/bowel obstruction, and weight; and Individual #92 – cardiac disease, and dental).

None of the nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of status updates on the medical/behavioral health risk (the exceptions to this were Individual #2 – falls; Individual #297 – respiratory compromise, and polypharmacy/side effects; Individual #182 – dental; and Individual #515 – cardiac disease); a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

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

- In March 2016, when Individual #474 made a suicidal gesture of superficial cuts to his wrists, nursing staff did not conduct

and/or document assessments for mood, sleep, or suicidal ideation.

- On 2/22/16, Individual #297 had shortness of breath and was wheezing. He was admitted to the hospital. On 3/7/16, he was admitted to the Infirmary for reactive airway disease exacerbation. A nursing quarterly dated 2/3/16 through 5/26/16 indicated his IHCP was updated to include an action step to conduct respiratory assessments weekly. This was not frequent enough for someone with his respiratory risks and acute episodes. On 7/6/16, he was hospitalized again for status asthmaticus. Daily assessments should have been included in the IHCP for this individual.
- For Individual #242, no nursing assessments were implemented after he experienced a significant weight gain of 9.5 pounds in one month.
- After Individual #452 had 42 episodes of hypothermia during the previous ISP year and at least three additional episodes after the ISP meeting, the IHCP was not modified to include ongoing nursing assessments of environmental issues, such as temperature of the bedroom or placement of the individual near an air conditioner vent, skin temperature, clothing, if wet from incontinence, or analysis of hypothermia episodes.
- Individual #452 was fed via tube. However, even after a significant drop in weight and then a gain in weight in one month, nursing staff did not complete assessments addressing weight. In addition, Individual #452 was noted to have pulmonary edema, and if the IDT believed that this could have been part of the weight gain/loss issue, she should have been weighed more than monthly.
- The dentist noted Individual #182's dental status was not any better and did not think her teeth were being brushed. However, her IHCP was not revised to include ongoing nursing assessments of her dental health and/or dental care.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: f. The IHCP that specified the frequency for monitoring of the individual's health risks was for Individual #2 – respiratory compromise.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: The PNMT was not consistently providing needed reviews and/or assessments for individuals with physical and nutritional management-related needs that met criteria for referral to and/or review by the PNMT. In addition, when the PNMT completed assessments, they were not timely, and many issues were identified with regard to the quality of the assessments. Scores during this review showed some regression from the last review. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	33% 2/6	N/A	1/1	0/1	1/1	0/1	N/A	0/1	0/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	17% 1/6		1/1	0/1	0/1	0/1		0/1	0/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/6		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.	0% 0/6		0/1	0/1	0/1	0/1		0/1	0/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	17% 1/6		0/1	0/1	1/1	0/1		0/1	0/1	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/6		0/1	0/1	0/1	0/1		0/1	0/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses:	0% 0/2		N/A	0/1	0/1	N/A		N/A	N/A	

	• 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.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5		0/1	N/A	0/1	0/1		0/1	0/1	

Comments: a. through d., and f. With regard to the six individuals that should have been referred to and/or reviewed by the PNMT:

- For Individual #2, on 7/2/15, in response to a referral, the PNMT initiated an assessment, but it was not completed until 10/2/15. The PNMT assessment was for weight loss. However, on 12/2/15, while the PNMT was still following her, she had an aspiration event. Other than a quick mention in the minutes of the event, there was no substantive discussion of the event and the possible need for additional assessments. OT consults that occurred post-event focused only on adaptive equipment and did not provide assessment of oral functioning. In addition, the assessment for weight loss did not explore possible therapy components that might have addressed the weight issue, such as the build-up of appetite through physical exercise or the improvement of swallow function to help address fatigue. Despite the fact that medications were a potential concern, Pharmacy Department staff were not involved in the PNMT assessment.
- Individual #297 had a history of aspiration pneumonia as well as other respiratory issues. However, when on 2/19/16, he was diagnosed with pneumonia, there was no evidence the PNMT reviewed him, even though the PNMT RN identified the need to review him and determine the need for services.
- Individual #242 was appropriately referred to the PNMT for weight loss issues. However, the PNMT consultation occurred on 12/7/15, but the PNMT review did not begin until 12/11/15. The PNMT did not initiate an assessment until 12/21/15, and did not complete it until 1/15/16. Despite the potential impact of GI issues/small bowel obstruction, the PNMT did not include the PCP. In addition, in February 2016, Individual #242 was diagnosed with bilateral pneumonia. This was mentioned as a brief one-line statement in the PNMT minutes, but no additional evidence was submitted of discussion or review. Individual #242 was at high risk of aspiration, was losing weight, and coughing during meals. Based upon multiple indicators pointing towards the potential for the bilateral pneumonia to be connected to aspiration, at least a thorough PNMT review was warranted.
- On 2/25/16, Individual #452 was diagnosed with acute respiratory failure, and on 3/18/16 and 6/15/16, she was diagnosed with aspiration pneumonia, but the IDT and/or the PNMT did not evaluate her. The PNMT RN completed a post-hospitalization assessment, but evidence was not submitted to show that the PNMT thoroughly discussed her.
- Individual #515 had a history of aspiration pneumonia and respiratory issues. On 5/5/16, she was diagnosed with aspiration pneumonia. Upon her return from the hospital, the PNMT RN conducted a post-hospital review, but there was no evidence that the PNMT thoroughly discussed her and /or documented a clinical justification for not adding her to their caseload and conducting an assessment. On 7/11/16, Individual #515 died at the age of 51 with causes of death listed as aspiration pneumonia and chronic aspiration from dysphagia.
- Individual #503 had a history of aspiration pneumonia and recently experienced a severe change in status, resulting in her

inability to safely tolerate oral intake. Due to the increased risk of aspiration as a result of changes in positioning, intake, and her overall instability that had the potential to impact multiple areas related to physical and nutritional management, the PNMT should have conducted an assessment, but did not.

h. For the two individuals for whom the PNMT conducted assessments, on a positive note, the PNMT Comprehensive Assessments:

- Described the presenting problem;
- Reviewed applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification; and
- Provided evidence of observation of the individual's supports at his/her program areas.

Problems with PNMT assessments varied, but in both assessments, four or more of the following components were missing or incomplete:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Review of the individual's behaviors related to the provision of PNM supports and services;
- Discussion of medications that might be pertinent to the problem, and discussion of their relevance to PNM supports and services;
- Assessment of current physical status.
- Discussion as to whether existing supports were effective or appropriate;
- Identification of the potential causes of the individual's physical and nutritional management problems;
- Recommendations, including rationale, for physical and nutritional interventions; and
- Recommendations for measurable goals/objectives, as well as indicators and thresholds.

The PNMT was not consistently providing needed reviews and/or assessments for individuals with physical and nutritional management-related needs that met criteria for referral to and/or review by the PNMT. In addition, when the PNMT completed assessments, they were not timely, and many issues were identified with regard to the quality of the assessments. For example, the PNMT had not consistently identified the etiology/cause of the problem, and the steps necessary to mitigate risk. Similarly, the analysis of the effectiveness of current supports often was not clear, making it unclear what, if anything, needed to change. The PNMT often did not clearly define individualized clinical indicators to assist IDTs in identifying when the individual was healthy and/or when deterioration was potentially occurring. In addition, disciplines that should have been involved in the PNMT assessment were not. The Center should focus on ensuring that individuals who need PNMT involvement have it, and on improving the quality of the PNMT's reviews and assessments.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Minimal improvement and some regression were noted with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	The individual has an ISP/IHCP that sufficiently addresses the	11%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2

	individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	2/18									
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	44% 4/9	0/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	83% 15/18	0/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	11% 1/9	N/A	0/1	1/1	0/1	0/1	0/2	0/1	0/1	0/1
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	1/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: falls, and weight for Individual #474; weight, and aspiration for Individual #2; falls, and aspiration for Individual #297; weight, and aspiration for Individual #242; skin integrity, and aspiration for Individual #452; choking, and aspiration for Individual #182; skin integrity, and aspiration for Individual #515; skin integrity, and aspiration for Individual #503; and weight, and aspiration for Individual #92.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exceptions were for aspiration for Individual #503, and weight for Individual #92.

b. The IHCP that included preventative physical and nutritional management interventions to minimize the individual's risks was for weight for Individual #92.

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs and/or Dining Plans for Individual #297, Individual #452, Individual #503, and Individual #92 included all of the necessary components to meet the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example, discrepancies existed between the adaptive equipment listed in the PNMP, and the Dining Plan, or the most recent OT/PT assessment (i.e., for Individual #474, and Individual #515, respectively). Based on review of assessment information (e.g., OT/PT assessments, Modified Barium Swallow Studies, etc.), and/or the ISP, mealtime plans did not fully or accurately define supports (e.g., Individual #474, Individual #2, Individual #242, and Individual #182). In addition, for Individual #2, the PNMP did not include the strategies contained within the SLP assessment

e. Although as discussed elsewhere, individuals' goals/objectives were not clinically relevant and related data could not be used to measure progress effectively, IDTs often identified in the IHCPs the necessary clinical indicators to measure the goals upon which they had agreed, as well as persons responsible for collecting the information. The exceptions were those for falls, and weight for Individual

#474, and aspiration for Individual #297. f. The IHCP that identified triggers and actions to take should they occur was for aspiration for Individual #297. g. The IHCPs reviewed often did not define the frequency of PNMP monitoring in alignment with individuals' needs.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: Compared to the last review, the Center had shown regression with these indicators.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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.	50% 3/6	N/A	N/A	0/1	N/A	0/1	1/1	1/1	0/1	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.	0% 0/2			0/1		N/A	N/A	N/A	0/1	N/A
Comments: a. Clinical justification for total or supplemental enteral nutrition was found in the PNMT minutes, the IRRF, and/or the ISP for three of the six individuals reviewed. Concerns were noted for the remaining three individuals. For example, in Individual #503's IRRF in the Medical Necessity for Continued Enteral Eating section, the IDT only stated: "Due to recent g-tube placement and her adjusting to enteral nutrition, there is not an immediate plan to return to oral eating. Prior to any attempts at recreational eating/drinking a MBS study should be performed to ensure her safety…" This conclusion did not provide the justification for why the individual required the tube, or set forth a specific plan to determine if/when she could tolerate oral feeding or progress along the continuum. In other words, the IDT needed to provide a description of the clinical reasoning for the tube's recent placement and the individual's current status that necessitated continued use of the tube. Although the IRRF included some of the reasons the IDT asked for consideration of tube placement, the IDT did not delineate the specific clinical reasons the medical team gave for actually placing the tube. In addition, the IDT needed to set forth a plan with specific timeframes for reassessment to determine whether or not there was continued medical necessity. Justification for continued necessity would need to include identification of the specific deficits preventing movement along the continuum to oral eating. Such a plan also should include indicators by which readiness for oral intake will be measured. These indicators of progress should be reviewed at a minimum annually, but sooner if the indicators of progress are met. b. In 2001, Individual #297 received recreational/pleasure feeding, but no explanation/rationale was documented as to why this was discontinued. In 2005, the last Modified Barium Swallow Study (MBSS) showed severe issues, but no aspiration or penetration. The IRRF only stated that the IDT had no plan to resume oral intake due to severe dysphagia.											

Individual #503's G-tube was a recent change, and the IDT indicated an MBSS would need to be completed prior to consideration of her resuming oral intake. However, the IDT had not identified a timeframe or parameters for reassessment.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Minimal, if any, improvement was noted with regard to the timeliness or quality of OT/PT comprehensive assessments and updates. Of particular concern, was the significant deficits noted in relation to the OT/PT updates. They did not provide IDTs with the information needed to identify individuals' current strengths and needs, and develop plans to meet their needs while incorporating their preferences. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	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.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	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.	38% 3/8	0/1	0/1	1/1	1/1	0/1	0/1	1/1	N/A	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	11% 1/9	1/1	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;	N/A									

	▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.											
d.	Individual receives quality Comprehensive Assessment.	50% 1/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	N/A	0/1

Comments: a. and b. Three of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:

- Individual #503 returned from a community transition, and the OT/PT conducted only a review of old assessments, and did not complete a comprehensive assessment. Given that she had experienced a significant change in status, a comprehensive assessment was warranted. If/when her health improved, then another comprehensive assessment might be needed.
- On 8/29/15, the IDT requested an OT consultation for Individual #474's hand tremors, but it was not completed until 11/9/15.
- Individual #2's last annual update was completed on 6/3/15. No annual update was provided for Individual #452. For Individual #92, no assessment was provided, just a review, which did not meet the agreed-upon requirements.
- On 12/11/15, Individual #182's comprehensive assessment was completed for an ISP meeting held on 12/15/15. At the ISP meeting, the IDT requested a consultation related to bicycle riding, and assigned a due date of 3/15/16, but it was not completed until 4/26/16.

d. On a positive note, the comprehensive assessment for Individual #182 included the necessary components, and addressed the individual's strengths, needs and preferences, as appropriate.

e. Overall, the updates submitted generally did not meet the agreed-upon standards. Information included was vague, and often focused on one issue/need area, as opposed to providing a review of all relevant areas and topics. Reference to previous updates that addressed specific areas of need did not provide IDTs with information in a usable format, and without a comparative analysis made the individual's current status unclear. They did not provide assessment to the depth and intensity necessary to identify and address individuals' needs. In addition, the updates often did not provide clinical justification for recommendations (e.g., head-of-bed elevations for Individual #503 and Individual #242). Moving forward, the Center should focus on ensuring updates include, as appropriate:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;

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

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.											
Summary: Over the last two reviews and this one, the Center's scores for these indicators varied. However, improvement was needed for all of these indicators, and they will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	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.	67% 6/9	0/1	0/1	1/1	1/1	1/1	1/1	0/1	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.	22% 2/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	50% 2/4	N/A	1/1	N/A	N/A	1/1	0/1	N/A	N/A	0/1

Comments: c. and d. Examples of concerns noted included: • Individual #474's OT/PT assessment recommended 30 to 60 minutes per day of exercise. This was reduced to 20 to 30 minutes with no clear justification. • The assessment recommended a dressing SAP for Individual #2, but the IDT did not include it in the ISP and did not provide justification. • Individual #503's ISP did not include the recommendation for a SAP to improve her deconditioning. • Individual #92's ISP did not incorporate recommendations to improve his activities of daily living skills, or provide justification for not including them. • For Individual #182, once the consultation related to use of a bicycle was completed on 4/26/16, no evidence was submitted of an IDT meeting to discuss the findings or to develop needed SAPs. • On 4/12/16, the OT/PT consult was completed for Individual #92 regarding pain when bathing. The OT/PT consult included a recommendation for an orthopedic or pain management consultation, but there was no ISPA meeting to discuss this and no evidence these consults were completed.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Over the last two reviews and this one, the Center's scores for the indicators related to the timeliness of communication assessments varied slightly. Center staff need to consistently conduct assessments timely, and most importantly, conduct assessments in accordance with individual's needs. In other words, it is important that individuals receive comprehensive communication assessments and/or updates at the frequency necessary to address their needs, including changes of status. In addition, Center staff need to focus on improving the quality of communication assessments.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	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	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A

	admission.										
	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.	50% 4/8	1/1	1/1	0/1	1/1	0/1	0/1	0/1	N/A	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	44% 4/9	1/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental 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	N/A	0/1	N/A	N/A	N/A	0/1	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/7	0/1	0/1	0/1	N/A	0/1	0/1	0/1	N/A	0/1

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

- Individual #503 returned from a community transition, and the Speech Language Pathologist conducted only a review of old assessments, and did not complete a comprehensive assessment. Given that she had experienced a significant change in status, a comprehensive assessment was warranted. If/when her health improved, then another comprehensive assessment might be needed.
- Individual #297 was due for an update, but the documentation submitted did not constitute an update.
- Individual #452's last assessment was completed in 2012. The SLP had not completed updates, despite Individual #452 having a goal related to an environmental device to help teach cause and effect and a SAP that focused on improving attention. Due to the progressive brain damage caused by bulbar paresis, updates would be warranted to compare and contrast communicative functioning.
- Individual #182 had communication-related SAPs. The SLP should have completed an update, but did not.

- For Individual #515, the 2013 assessment included recommendation to initiate a goal related to speech in the form of sound localization. The SLP should have completed an update, but did not.

d. and e. As noted above, five individuals should have had updates or comprehensive assessments completed, but did not. Problems varied across the remaining assessments and updates, but in each of the remaining assessments or updates one or more of the key components were insufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should focus on ensuring 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.	
Summary: In comparison to the previous two reviews, improvement was noted with regard to individuals' ISPs describing how they communicate and providing staff with information about how best to communicate with them. The Center is encouraged to continue its efforts in this regard. During this review and the previous two, findings showed that IDTs reviewed individuals Communication Dictionaries annually, which was good to see. Improvement also was noted since the Round 9 review with regard to the Communication Dictionaries comprehensively addressing individuals' non-verbal communication (i.e., Round 9 – 63%, Round 10 – 100%, and Round 11 – 100%). If the Center maintains this progress, during the next review, Indicator b likely will move to the category requiring less oversight. Efforts are needed to ensure that ISPs include strategies,	Individuals:

interventions, and programs that SLPs recommend in communication assessments, unless the IDT provides justification for not including them.											
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	100% 8/8	N/A	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.	44% 4/9	0/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: a. It was good to see that for the individuals reviewed, their ISPs described how the individual communicates, and how staff should communicate with the individual. b. It was also positive that evidence was present to show that the IDTs of the individuals reviewed had reviewed their Communication Dictionaries, and the Communication Dictionaries comprehensively addressed the individuals' non-verbal communication.											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
Summary: Individuals had at least three skill acquisition plans and they were measurable. This was the case for this review and the previous two reviews. Therefore, these two indicators will move to the category of requiring less oversight. The other three indicators will remain in active monitoring. Ensuring that SAPs are based on assessment results; are practical, functional, and meaningful; and reliable and valid data are available are important areas of focus for the facility.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225

#	Indicator	Overall score									
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	96% 26/27	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	2/3
3	The individual's SAPs were based on assessment results.	52% 14/27	3/3	1/3	3/3	1/3	1/3	3/3	0/3	0/3	2/3
4	SAPs are practical, functional, and meaningful.	41% 11/27	1/3	1/3	3/3	1/3	1/3	2/3	0/3	0/3	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	12% 3/26	1/3	1/3	0/3	0/3	0/3	0/3	0/3	1/3	0/2

Comments:

1. Each of the individuals reviewed had multiple SAPs.

2. All, but one, of the 27 SAPs were identified as measurable. The exception was the baking SAP for Individual #225 because this did not address specific baking skills. It was a broad based goal to learn to bake.

3. Fourteen of the 27 SAPs were based on assessments. Exceptions included skills that had been identified as mastered in the individual's functional skills assessment (Individual #530 – greeting and setting the table, Individual #570 – greeting others, Individual #2 – dressing, Individual #474 – making a purchase and bathing, Individual #222 – exercising, Individual #225 – showering). In other cases, it was not clear that the skill had been assessed or that baseline measures had been collected to determine whether exposure to the task would result in the individual learning the skill (Individual #570 – keeping his reinforcement card in his wallet, Individual #2 – using remote, Individual #474 – using a blood pressure cuff, Individual #222 – schedule making). Lastly, Individual #222's functional skills assessment indicated she demonstrated most components of a laundry skill. It was unclear whether she simply needed to learn to chain these components together.

4. Eleven of the 27 SAPs were considered to be practical, functional, and/or meaningful. In addition to those skills that were identified as mastered, exceptions included the following: counseling cards for Individual #95, which addressed generalization of a skill he was learning in counseling; Individual #95's working an entire shift, a SAP he had been working on for close to three years; Individual #2's going to work, which addressed compliance versus development of a new skill; Individual #474 learning to take his blood pressure as the SAP did not teach him to read or record the measure; Individual #222 learning to create a schedule as this was not portable and therefore not practical in developing greater independence; and Individual #225's showering because this addressed compliance rather than a new skill.

5. Of the 26 SAPs that had been implemented by the time of the visit, there was evidence that three SAPs had been monitored for data reliability multiple times over a six-month period.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.											
Summary: These criteria related to assessments were not met for all individuals. The importance of the assessments to inform the IDT in choosing SAPs cannot be overstated. The facility's performance has remained about the same for three consecutive reviews. The facility should be able to focus upon these indicators and improve performance for the next review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
10	The individual has a current FSA, PSI, and vocational assessment.	44% 4/9	0/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	56% 5/9	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	78% 7/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:

10. Four of the nine individuals (Individual #2, Individual #554, Individual #474, Individual #225) had current assessments. The preferences and skills inventory was not available for Individual #95, Individual #530, and Individual #570. The functional skills assessment summary was not current for either Individual #93 or Individual #222. While vocational assessments were not completed for the three school-age individuals, the facility may want to complete these, particularly for Individual #554 and Individual #474, both of whom will be turning 18 over the next one to five months.

11. As indicated by the individual's QIDP tracking data and review of the documents provided, the required assessments were available by the identified due date for five of the nine individuals (Individual #93, Individual #554, Individual #474, Individual #222, Individual #225). It should be noted that the functional skills summary submitted for Individual #222's September 2015 ISP was completed the previous year.

12. For seven of nine individuals (Individual #95, Individual #530, Individual #570, Individual #554, Individual #474, Individual #222, Individual #225), required assessments included SAP recommendations. These varied in quantity and quality. If SAP recommendations were included in the vocational assessments, these were limited to one goal. In some cases (e.g., Individual #95, Individual #222), the SAP addressed continuation of previously implemented plans. The number of SAP recommendations provided in the functional skills assessment ranged from a low of one for Individual #93 to a high of eight for Individual #474. As this assessment addresses a broad range of skill domains, it is suggested that a comprehensive range of potential SAPs be identified.

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

This Domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Twenty-three of these indicators, in restraints, psychiatry, behavioral health, medical, pharmacy, dental, and OT/PT, had sustained high performance scores and will be moved to the category of requiring less oversight. Three Outcomes will move entirely to less oversight: Outcomes #8, 12, and 14 for psychiatry.

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

Goals/Objectives and Review of Progress

For behavioral health services, Abilene SSLC had good reliable data for two of the individuals. This was good to see, but needs to occur more often. Neither of the two individuals was making progress. The ability to determine progress was impeded, in part, by inadequate data collection and graphing systems (adequate systems were in place for but a third of the individuals, and data graphs were not created in a way that they were useful to practitioners). There were, however, some strengths: staff training on PBSPs was occurring, PBSPs were written and supervised by certified behavioral health services staff for all individuals, behavioral health progress notes commented on the individual's status, and behavioral health services' peer review was up and running, and had been for some time now.

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

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. On a positive note, QIDPs had begun to include some data related to individuals' IHCP goals/objectives in their monthly reviews. The need to succinctly summarize and analyze the data remained, and without clinically relevant goals/objectives, the data could not yet be used to measure individuals' progress. However, as IDTs improve the quality of the goals and objectives in IHCPs, this practice of collecting and listing related data in the monthly reviews will provide a good start to IDTs' measurement of progress or lack thereof.

Acute Illnesses/Occurrences

Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments, suggestions for non-pharmacologic approaches) were developed and implemented. Interim psychiatric clinics were held for all individuals, when needed.

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

It was positive that for the individuals reviewed who required Emergency Department visits, hospitalizations, or Infirmary admissions, providers timely evaluated individuals prior to the transfer, or if unable to assess prior to transfer, within one business day, provided an IPN with a summary of events leading up to the acute event and the disposition; as appropriate, documented a quality assessment in the IPN; and provided treatment and/or interventions for the acute illness. It was also good to see that for the individuals reviewed, upon their return to the Facility, there was 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. The Facility should focus on developing post-hospital ISPAs for individuals that address follow-up medical and healthcare supports to reduce risks and increase early recognition, as appropriate.

It was concerning that often IDTs did not refer individuals meeting criteria for PNMT review and/or assessment to the PNMT and/or that the PNMT did not self-refer these individuals.

Implementation of Plans

Psychiatry quarterly clinics and polypharmacy reviews occurred regularly and those observed by the Monitoring Team met the various criteria. Psychiatry worked well with behavioral health and information regarding behavior problems and psychiatric disorders was cross-referenced. There also was good collaboration between psychiatry and neurology. Attention needs to be paid to side effect monitoring review scheduling and documentation.

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

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

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

With regard to dental care and treatment, the Center made progress in providing individuals with necessary prophylactic dental care, provision of tooth-brushing instruction (i.e., to the individuals reviewed and/or their staff), and x-rays. Two new indicators relate to the provision of fluoride treatment as appropriate, and treatment for periodontal disease, which were completed for most of the applicable individuals. On a positive note, for the individuals reviewed with missing teeth, the dentist generally assessed the need for dentures. Given the Center's scores in recent reports on the related indicator, it will be placed in the category requiring less oversight.

Work was needed to ensure that the IHCPs of individuals requiring suction tooth brushing include measurable strategies, IDTs implement the strategies, monitoring occurs to ensure the quality of the technique, and ISP monthly reviews includes specific data reflective of the measurable strategies.

During this review, the Abilene SSLC Pharmacy Department was completing QDRRs timely, and practitioners generally reviewed them timely. In terms of quality of QDRRs, for the individuals reviewed, the Pharmacist consistently reviewed and made recommendations regarding polypharmacy and benzodiazepine use. However, at times, the Pharmacy Department did not review the most recent lab results, and/or did not further review abnormal or serial lab results to determine significance followed by recommendations, if clinically appropriate. The five risks of metabolic syndrome were not reviewed in the applicable QDRRs, and/or the Pharmacist did not make applicable recommendations. In addition, despite moderate to high anticholinergic activity/burden, which the Pharmacy Department identified, there often were no recommendations made to address these findings.

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

Based on observations, there were still numerous instances (67% of 40 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. This was particularly concerning given that PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.												
Summary: Many of these indicators met criteria for all four individuals. This was good to see and, moreover, a number of these indicators also had good performance at the last review, too. Two indicators showed high performance over this review and the past two reviews and will be moved to the category of requiring less oversight (indicators 19 and 29). With sustained performance, many of the other indicators might move to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	95	530	570	474						
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% 4/4	1/1	1/1	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% 4/4	1/1	1/1	1/1	1/1						
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	75% 3/4	0/1	1/1	1/1	1/1						
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 4/4	1/1	1/1	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% 4/4	1/1	1/1	1/1	1/1						
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining	100% 4/4	1/1	1/1	1/1	1/1						

	the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 4/4	1/1	1/1	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% 4/4	1/1	1/1	1/1	1/1					
26	The PBSP was complete.	N/A	N/A	N/A	N/A	N/A					
27	The crisis intervention plan was complete.	25% 1/4	0/1	0/1	1/1	0/1					
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.	25% 1/4	1/1	0/1	0/1	0/1					
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% 3/3	N/A	1/1	1/1	1/1					

Comments:

18-19. Of the nine individuals, four (Individual #95, Individual #530, Individual #570, Individual #474) had experienced more than three crisis intervention restraints in a rolling 30-day period. There was evidence that their IDTs had met within the required timeframe. There were a sufficient number of meetings of each individual's team. The behavioral services director reported that the facility had begun conducting this type of review following every occurrence of crisis intervention restraint. This was a positive step in trying to identify and respond to potential contributing variables.

20-23. Minutes from the IDT meetings reflected team discussion of all potential variables contributing to the use of restraint. Action plans included retraining of staff (Individual #570, Individual #530), introduction of new activities or enhanced availability of materials to improve engagement (Individual #95, Individual #530), and rearrangement of a cabinet to allow for a choice of snacks (Individual #530). Following an incident in the community, the team agreed to cancel future outings for Individual #570. While this may have been an appropriate short-term intervention, the team is advised to develop a plan for helping Individual #570 learn to recognize expected limitations in the spending that can occur. An exception was identified when reviewing the minutes from Individual #95's meetings. A staff member working with Individual #95 had informed him that he would be leaving to take another job. This was hypothesized as upsetting to Individual #95. It was not clear that a plan was identified to help Individual #95 cope with changes in staff or to develop guidelines for staff when relaying upcoming changes that would impact their relationship with Individual #95.

24-25. All four individuals had PBSPs and CIPs.

26. Review of the individual's PBSP can be found elsewhere in this report under indicator 15.

27. The CIP for Individual #570 was considered complete. However, staff are advised to describe the escort that is used versus labeling it as a Double Sunday Stroll. The behavioral services director explained that this was the term used in a crisis intervention program utilized in another state. Because the state of Texas does not use this program, the term does not apply. Further, staff are advised to identify the time out room versus identifying it at the family room.

The CIPs for Individual #95, Individual #530, and Individual #474 were incomplete. While each plan indicated that a release should be attempted at 15 minutes, none clearly indicated the allowed maximum duration of restraint. Further, there was different language describing Individual #474's safe behavior in different sections of his plan (i.e., body still and breathing steady versus no yelling or attempted struggling). The duration of safe behavior was not identified. Lastly, three of the four CIPs included references to the use of a respite home. Comments, concerns, and recommendations regarding this intervention are provided elsewhere in this report under indicator 15.

28. Evidence provided by the facility indicated that the PBSPs for Individual #95 and Individual #530 were implemented with at least 80% integrity. However, review of specific restraints indicated that staff had not been following Individual #530's PBSP. Staff retraining was the identified action plan.

29. Individual #95's PBSP had recently been revised/rewritten in preparation for his annual ISP meeting. There was evidence that the IDT reviewed the PBSPs for the other three individuals. Revisions were evident in the plans for Individual #570 and Individual #474.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.

Summary: Abilene SSLC routinely conducted Reiss screens for all individuals and had been doing so for a number of years. Therefore, indicator 1 will move to the category of requiring less oversight. Indicators 2 and 3 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	182	92	503	515	297	225			
1	If not receiving psychiatric services, a Reiss was conducted.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1			
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1			

Comments:

1. There were 16 distinct individuals in the combined medical and behavioral groups. Ten of these individuals were followed in the psychiatry clinics. Of the remaining six (Individual #182, Individual #92, Individual #503, Individual #515, Individual #297, Individual #225), all had the Reiss performed in 2010 and all but one had not been updated. 2. One of these individuals experienced a significant change in status that prompted a re-application of the Reiss. That was for Individual #225 dated 12/27/15 due to a significant change in mental status. It was good to see this example of using the Reiss when a change of status occurred. 3. The Reiss evaluation revealed a significantly elevated score of 25, but a CPE was not performed by the psychiatry department.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledged that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
8	The individual is making progress and/or maintaining stability.	0/8 0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0/8 0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	7/7 100%	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A
11	Activity and/or revisions to treatment were implemented.	7/7 100%	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A
Comments: 8-9. It was not possible to assess if the individual was making progress or maintaining stability because the appropriate goals had not been developed as described above in psychiatry outcome 2. This observation was also true for the determination of whether new goals were developed when the individual had achieved stability. 10-11. There was evidence that when there were indications that individual's status was deteriorating that the psychiatric providers would intervene via an urgent consult. The documentation also confirmed that the interventions that were recommended during these consultations were implemented. Documentation to support these observations was found for all seven individuals for whom these interventions were required.											

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Both indicators showed good improvement since the last review. This was good to see. With sustained performance, indicator 23 might move to the category of requiring less oversight after the next review. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
24	The psychiatrist participated in the development of the PBSP.	25% 2/8	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	N/A

Comments:
23. The psychiatric quarterlies, PTPs, and CPEs routinely referred to the behavioral aspects of the individual's presentation. It was also possible to find a reference to the psychiatric contributions to the individual's behavior in either the functional assessment or the behavioral health assessment for all of the individuals for whom this was required.

24. The documentation of the psychiatrist's participation was documented for Individual #474 by a note in the functional assessment. The psychiatry department had also developed a case formulation discussion form to document the discussions between the psychiatrist and the behavioral health specialist with reference to the psychiatrist's contribution to the formulation of the PBSP. These forms were not located in the electronic records produced prior to the review. However an onsite request produced theses forms for Individual #2, Individual #93, Individual #530, and Individual #222. The psychiatric provider had signed all of these, but the BCBA had only co-signed the form for Individual #2 and presumably if they had been present during the discussion, they would have been able to sign the others as well.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
Summary: Given the scores on this review and given that they were maintained over the last two reviews, too, these three indicators will be moved to the category of requiring less oversight. Moreover, the facility had a system that ensured documentation occurred regularly.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
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	1/1	N/A	N/A	N/A	N/A

26	Frequency was at least annual.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments:
25-27. There was only one individual for whom an anticonvulsant was used to treat a psychiatric disorder and a seizure disorder (Individual #2). This occurred recently when the Lamictal that was being used to treat the seizure disorder was increased to more effectively treat her mood disorder. Annual review beyond the current year was, thus, not applicable. Although as a general procedure, each psychiatric quarterly contained a section for the most recent neurology review for all individuals who are followed by neurology and the neurology notes made reference to the psychotropic medications.

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

Summary: Quarterly clinics were conducted quarterly, as required, at Abilene SSLC for this review and for a number of years. Further, the clinics observed by the Monitoring Team included the standard components for this review and the last two reviews, too. Therefore, these two indicators (33, 35) will move to the category of requiring less oversight. Indicator 34 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
33	Quarterly reviews were completed quarterly.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
34	Quarterly reviews contained required content.	50% 4/8	1/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1	N/A
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 2/2	1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments:
33. The psychiatric reviews were completed as required for all of the individuals for whom they were necessary.

34. The quarterly review documentation was complete for four of the individuals. The missing documentation for Individual #530, Individual #570, Individual #2, and Individual #474 related to the requirement for a discussion of whether the non-pharmacological interventions recommended by the psychiatrist and approved by the IDT were being implemented. This requirement relates to activities other than those that would be addressed in the PBSP. The facility's current quarterly review format did not contain a section for this information. However, the review of the narrative summary prepared by the psychiatric provider was sufficient to satisfy this requirement for the other four individuals. This issue was discussed with the lead psychiatrist during the onsite review.

35. The quarterly review for Individual #554 was observed on 8/30/16 and the review for Individual #95 was observed on 8/31/16. In addition to the psychiatrist, the meeting was attended by the RN case manager, the QIDP, the behavioral analyst, a direct service professional, and a psychiatric assistant. All of the required areas were covered in the discussions.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: The facility maintained mediocre performance on this indicator, primarily due to the schedule/ability of the department to ensure review by the provider. A look at the system for doing so is recommended. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	63% 5/8	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	N/A
Comments: 36. Both the MOSES and the DISCUS were completed for the all individuals for whom they were required and they were done so on a timely basis. There were deficits, however, in the review of these instruments by the psychiatric provider for three of the individuals. The 9/14/15 MOSES for Individual #554 was not reviewed and signed by the prescriber until 10/21/15; the MOSES for Individual #474 dated 1/12/16 was not reviewed by the provider until 2/1/16; and the DISCUS for Individual #222 dated 2/3/16 was not reviewed by the provider until 3/9/16.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: The availability, provision, and documentation of emergency/urgent and/or follow/up interim clinics met the criteria required for these indicators for a number of years. These three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A
Comments: 37-39. There was documentation for all seven of the individuals for whom it appeared to be necessary that met the criteria for these three indicators. The nature of the interventions were well documented in interim psychiatric consultations with follow-up in the subsequent quarterly review.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These indicators met criteria during this review and the two previous reviews. They will, however, remain in active monitoring. Some may be considered for less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 40-42. There was no indication that the psychotropic medications were utilized to produce sedation or for the convenience of staff. There was a behavioral treatment plan for each individual who was prescribed psychotropic medication. 43. There were no individuals who had PEMA plans and the facility did not routinely utilize these interventions.											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary: The review and management of polypharmacy met the criteria required for these indicators for a number of years. These indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 6/6	1/1	N/A	N/A	1/1	1/1	1/1	1/1	1/1	N/A
45	There is a tapering plan, or rationale for why not.	100% 6/6	1/1	N/A	N/A	1/1	1/1	1/1	1/1	1/1	N/A
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 6/6	1/1	N/A	N/A	1/1	1/1	1/1	1/1	1/1	N/A

Comments:
46. The monthly meeting of the polypharmacy committee was chaired by the clinical pharmacist and attended by all of the psychiatric providers as well as a primary provider of medical services. Individuals who were stable and for whom the efficacy of the psychotropic medications had been justified were reviewed quarterly. Individuals who were recently admitted, were considered to not be stable, or for whom the efficacy of their psychotropic medications was still being established were reviewed monthly. The proceedings of the meetings were summarized in minutes that also include the pertinent historical information that documented the efficacy of the medications. Six of the individuals met the criteria for polypharmacy. The Monitoring Team attended the monthly meeting that occurred on 8/30/16.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Given the absence of good, reliable data, progress could not be determined for seven individuals. For the two individual who had good, reliable data, progress was not occurring. The Monitoring Team scored indicators 8 and 9 based upon the facility's report of progress/lack of progress as well as the ongoing exhibition of problem target behaviors. When individuals were exhibiting ongoing problem behaviors, actions were developed, but not always implemented. The four indicators in this outcome will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
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.	100% 6/6	N/A	1/1	1/1	1/1	N/A	N/A	1/1	1/1	1/1
9	Activity and/or revisions to treatment were implemented.	67% 4/6	N/A	0/1	1/1	1/1	N/A	N/A	0/1	1/1	1/1
Comments: 6. Although graphs included in the progress notes indicated stable or descending trends for some problem behaviors identified for Individual #95, Individual #530, Individual #93, Individual #2, Individual #554, and Individual #225, this indicator was rated as zero for all nine individuals. For the two individuals for whom reliable data were available, due to the increased report of medication refusals, a lack of progress was recorded for Individual #93; and data for Individual #222 showed increasing trends for behavior targets. In Individual #95's case, data were not reliable and the use of restraint had increased over a 12-month period. For Individual #530, Individual #2, Individual #554, and Individual #225, progress could not be determined due to the lack or reliable data.											

7. Based upon the data provided, none of the individuals had met their goals/objectives.

8-9. Recommendations were provided for six of the individuals. There was evidence of implementation of programs (Individual #93 – accu-check SAP), revisions to the PBSP (Individual #570, Individual #222), and completion of recommended consultations and medical exams (Individual #225). Individual #530's PBSP included a DRO contingency to reduce soiling. Identification of appropriate edible reinforcement was recommended, but not implemented for three consecutive months. Similarly, Individual #474's progress notes included the same recommendations for three consecutive months. Although one recommendation addressed the effectiveness of reinforcers, there was no evidence of an updated preference assessment. Further, his PBSP indicated that problem behavior was more likely to occur when he had nothing to do, but there was no evidence of planning for enhanced activities during his upcoming summer vacation.

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

Summary: Abilene SSLC demonstrated excellent performance on this outcome. All three indicators scored at 100%. Further, this was an improvement from the last review for indicators 16 and 17. Indicator 17 has been at 100% for this and the last two reviews and will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring, but with sustained performance might move to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 95	530	93	570	2	554	474	222	225
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
17	There was a PBSP summary for float staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
16. It was very positive to see that for all nine individuals, over 80% of the staff regularly assigned to the home had been trained. This was particularly commendable because training records indicated that 100% of these regularly assigned staff had been trained for six individuals (Individual #95, Individual #530, Individual #93, Individual #570, Individual #222, Individual #225). Additionally, training for all individuals had been provided to staff in the behavioral services department. Although the Monitoring Team did not receive names of activity center or work site staff, there was evidence that staff from one or both of these settings had been trained for three individuals (Individual #95, Individual #93, Individual #225). Training records also indicated that float staff had been trained of the PBSP for four individuals (Individual #93, Individual #570, Individual #554, Individual #222).

17. Behavioral services staff developed PBSP summaries, in the form of a Do's and Don't's sheet for all nine individuals. These included operational definitions of problem behaviors, a description of replacement/alternative behaviors, and some antecedent strategies. Four were a single page in length, five stretched onto second page. It would be helpful to ensure that these summaries are dated and include brief guidelines regarding action to take when problem behaviors do occur.

18. All functional assessments and PBSPs were either written by a BCBA or reviewed and signed off on by a BCBA.

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

Summary: Abilene SSLC regularly included comments in progress notes and regularly held peer review as per the criteria. This was the case at this review and the last two reviews. Therefore, indicators 19 and 23 will move to the category of requiring less oversight. Attention and focus needs to be paid to the quality of the graphic summaries (indicator 20), which will make the presentation of the data relevant and useful to the IDT (indicator 21). Indicator 22 showed good performance and if maintained this indicator may move to the category of requiring less oversight after the next review. Indicators 20, 21, and 22 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 95	530	93	570	2	554	474	222	225
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.	0% 0/9	0/1	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% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 5/5	1/1	1/1	1/1	1/1	N/A	N/A	N/A	1/1	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

Comments:

19. The progress note for all nine individuals commented on the individual's progress. This included comments regarding progress in counseling for the three individuals receiving this service (Individual #95, Individual #570, Individual #474).

20. For none of the nine individuals were the graphs determined to be useful for data-based decisions. For six individuals (Individual #95, Individual #530, Individual #570, Individual #554, Individual #474, Individual #225), phase change lines were not consistently used to depict medication changes, revisions to the PBSP, or other significant events. In other reports (Individual #95, Individual #530, Individual #93, Individual #2, Individual #554, Individual #222, Individual #225), the label on the vertical axis did not consistently correspond to the behavioral objective and/or the system of data collection. This was found in graphs for both targeted problem behaviors and replacement/alternative behaviors.

21. An observation was conducted of the psychiatric clinic for one individual, Individual #554. The BCBA reviewed data, including measures collected for the month in which the clinic was held. As discussed with the BCBA, it would be helpful to have hard copies of graphs, so that everyone present can review the visual display for trends, events that impacted the target behavior, etc. Overall, there was very good discussion, with input from all team members, in particular, the BCBA, home manager, nurse, and psychiatrist.

22. There was evidence that seven individuals had been reviewed in internal and/or external peer review meetings. For five of these seven individuals (Individual #95, Individual #530, Individual #93, Individual #570, Individual #222), recommendations were provided and implemented. The minutes from the meetings in which Individual #554 and Individual #225 were reviewed did not identify recommendations.

23. There was evidence that over a six-month period, internal peer review occurred at a minimum of three times each month and external peer review occurred monthly.

Outcome 8 – Data are collected correctly and reliably.											
Summary: Four of the indicators showed continued progress. Indicator 26 did not. It was good to see that Abilene SSLC had established measures and goals for data timeliness, IOA, and treatment integrity. Given the need for sustained performance, as well as the state's new implementation of the electronic record and data collection system, these indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	33% 3/9	0/1	0/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	22%	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1

		2/9								

Comments:
26. For three of the nine individuals (Individual #570, Individual #554, Individual #474) data collection as described in the PBSP was considered adequate. For Individual #93, Individual #2, and Individual #222, targeted problem behaviors were recorded using a partial interval measurement within 30-minute intervals. For Individual #95 and Individual #530, a frequency count was identified, but 10 or 15 minutes, respectively, without target behavior had to pass to record another episode. Lastly, the instructions in Individual #225's plan noted that staff should record data on scatterplots, but did not specify whether this was a frequency or partial interval recording. The facility often utilized a frequency measure within identified intervals of time. Additional concerns regarding lack of correspondence across data collection, graphic presentation, and behavioral objectives are reviewed in indicator 20 above.

27. All of the PBSPs included adequate measures of replacement behaviors, although these were often limited to one occurrence per shift.

28-29. The behavioral health services department provided documentation indicating that data timeliness was to be assessed weekly, with IOA and treatment integrity assessed at a minimum of once monthly. It was positive that the schedule of IOA and treatment integrity was individualized based upon the complexity of the PBSP. This individual-specific schedule was identified in the PBSP. Data timeliness indicated that data were recorded within two hours of the data check. IOA and treatment integrity were expected to be 80% or better.

30. Goal frequencies and levels for data collection timeliness, IOA, and treatment integrity were achieved for two of the nine individuals (Individual #93, Individual #222).

Medical

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

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

#	Indicator	Overall Score	Individuals: 474	2	297	242	452	182	515	503	92
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.	33% 6/18	1/2	1/2	0/2	0/2	1/2	1/2	0/2	1/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	0/2	N/A	0/2

d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	0/2	N/A	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	0/2	N/A	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 #474 – cardiac disease, and weight; Individual #2 – respiratory compromise, and constipation/bowel obstruction; Individual #297 – aspiration, and osteoporosis; Individual #242 – gastrointestinal (GI) problems, and weight; Individual #452 – respiratory compromise, and other: hypothyroidism, and hypothermia; Individual #182 – GI problems, and osteoporosis; Individual #515 – aspiration, and urinary tract infections (UTIs); Individual #503 – GI problems, and cardiac disease; and Individual #92 – aspiration, and weight].

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 #474 – weight; Individual #2 – constipation/bowel obstruction; Individual #452 – respiratory compromise; Individual #182 – GI problems; Individual #503 – GI problems; and Individual #92 – weight.

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

Outcome 4 – Individuals receive preventative care.

Summary: Seven of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be fully assessed and are deemed to meet the requirements of the Settlement Agreement. In addition, the Center needs to continue to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Individuals:

#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	80% 4/5	N/A	1/1	N/A	1/1	N/A	N/A	1/1	1/1	0/1

	iii. Breast cancer screening	100% 4/4	N/A	1/1	N/A	N/A	N/A	1/1	1/1	1/1	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	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 7/7	N/A	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	43% 3/7	1/1	0/1	1/1	0/1	1/1	N/A	N/A	0/1	0/1
Comments: a. Overall, the individuals reviewed received timely preventive care, which was good to see. Individual #182 had refused pap smears, even with oral sedation. Based on review of documentation, it appeared that a nurse contacted the guardian who verbally agreed that pap smears were not necessary. This individual appeared to be at low risk for gynecologic pathology, so the Center's recommendation to discontinue the pap smears appeared to have merit. However, the Center provided no ISPA documentation and/or no written confirmation from the guardian (i.e., a signed document) to show that Center staff had explained the risks and benefits of discontinuing pap smears and the guardian made an informed decision. Comments: b. For Individual #474, Individual #297, and Individual #452, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence was present that the prescribing medical practitioners addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. For example, the PCPs for these individuals provided rationales for the applicable medication regimens, and discussed whether or not any side effects were reported.											

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	50% 1/2	N/A	N/A	0/1	N/A	N/A	N/A	1/1	N/A	N/A
Comments: Individual #297's ISP stated: "OOH DNR based on his irreversible condition of severe dysphagia, possibly due to his Pelizaeus-Merzbacher disease and cerebral palsy. Without his life-sustaining enteral feedings, this would be a terminal condition." On 5/28/15, an ethics committee meeting was held. It was documented that the Education Department would not train on "no chest											

compressions" as this was not part of their approved curriculum.

On 3/7/16, Individual #515's AMA indicated that she was designated for a full code. On 7/7/16, due to respiratory failure and recurrent aspiration, a DNR Order was put in place when she was put into hospice care. She died on 7/11/16.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Given that over the last two review periods and during this review, prior to the transfer to the hospital or ED, individuals reviewed received timely treatment and/or interventions for the acute illness requiring out-of-home care (Round 9 – 100% for Indicator 4.e, Round 10 – 86% for Indicator 4.e, and Round 11 - 100% for Indicator 6.e), Indicator e will move to the category requiring less oversight. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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.	50% 8/16	1/2	2/2	0/2	0/2	1/2	N/A	1/2	2/2	1/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	83% 10/12	0/2	2/2	2/2	1/1	1/1		N/A	2/2	2/2
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 7/7	N/A	N/A	2/2	N/A	2/2	1/1	2/2	N/A	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 4/4			2/2		1/1	1/1	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.	100% 4/4			1/1		2/2	N/A	1/1		
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	75% 3/4			0/1		2/2	N/A	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.	0% 0/2			0/1		0/1	N/A	N/A		
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 6/6			2/2		2/2	N/A	2/2		

Comments: a. and b. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 16 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #474 (fall with abrasion on 5/12/16, and ear pain on 4/9/16), Individual #2 (sacral wound on 6/16/16, and buttocks wound on 5/3/16), Individual #297 (respiratory distress on 4/1/16, and dermatitis on 3/21/16), Individual #242 (ankle swelling on 6/27/16, and rash on 2/4/16), Individual #452 (increased secretions on 6/6/16, and wheezing on 2/28/16), Individual #515 (J-tube required advancing on 6/11/16, and emesis on 6/8/16), Individual #503 (constipation on 6/21/16, and fever on 7/2/16), and Individual #92 (skin lesions on 4/4/16, and right shoulder pain on 3/11/16).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #474 (ear pain on 4/9/16), Individual #2 (sacral wound on 6/16/16, and buttocks wound on 5/3/16), Individual #452 (wheezing on 2/28/16), Individual #515 (emesis on 6/8/16), Individual #503 (constipation on 6/21/16, and fever on 7/2/16), and Individual #92 (right shoulder pain on 3/11/16). For many of the remaining acute illnesses treated at the Center that the Monitoring Team reviewed, medical providers did not cite the source of the information.

The acute illnesses/occurrences reviewed for which follow-up was needed, but documentation was not found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized included those for Individual #474 (fall with abrasion on 5/12/16, and ear pain on 4/9/16).

For four of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses requiring hospital admission, ED visit, or Infirmary admission, including the following with dates of occurrence: Individual #297 (status asthmaticus on 7/6/16, and reactive airway disease on 3/4/16), Individual #452 (hypoxia on 6/16/16, and aspiration pneumonia on 3/18/16), Individual #182 (Dilantin toxicity on 6/30/16), and Individual #515 (respiratory distress on 6/24/16, and hypothermia on 6/21/16).

c. through e. It was positive that for the individuals reviewed, providers timely evaluated individuals prior to the transfer, or if unable to assess prior to transfer, within one business day, provided an IPN with a summary of events leading up to the acute event and the disposition; as appropriate, documented a quality assessment in the IPN; and provided treatment and/or interventions for the acute illness.

f. The individual that was transferred to the hospital for whom documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff was Individual #297 (status asthmaticus on 7/6/16).

g. Concerns included:

- In response to an onsite request for the post-hospital ISPA for Individual #297's 7/6/16 hospital admission for status asthmaticus, the Center responded that there "is no evidence."
- For Individual #452, in response to an onsite request, an ISPA was submitted, dated 3/23/16. This meeting occurred during her hospitalization (i.e., she transferred back to ABSSLC on 3/28/16). As a result, the IDT was not able to review discharge recommendations and/or implement new plans in response to such recommendations. The ISPA documentation was lengthy and reviewed protocols put in place on 11/5/15. The PCP attended this meeting. There was no documentation submitted to

show that a post-hospital IDT meeting occurred.

h. It was good to see that for the individuals reviewed, upon their return to the Facility, there was 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.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: Although during the last review and this one, some improvement was seen with the Center's performance on these indicators, all of them will remain under active oversight. If the Center maintains its progress with regard to indicators a and b, then during the next review, they might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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% 14/14	N/A	2/2	2/2	N/A	2/2	2/2	2/2	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	93% 13/14		2/2	1/2		2/2	2/2	2/2	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	79% 11/14		2/2	1/2		2/2	2/2	2/2	2/2	0/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	70% 7/10		2/2	0/1		1/1	1/2	1/1	2/2	0/1
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

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 14 consultations. The consultations reviewed included those for Individual #2 for hematology on 5/12/16, and wound care clinic on 1/20/16; Individual #297 for cardiology on 4/1/16, and gastroenterology (GI) on 4/29/16; Individual #452 for GI on 4/25/16, and ophthalmology on 5/5/16; Individual #182 for ophthalmology on 5/3/16, and genetics on 1/26/16; Individual #515 for Ear, Nose, and Throat (ENT) on 2/15/16, and GI on 4/20/16; Individual #503 for neurology on 2/22/16, and GI on 6/28/16; and Individual #92 for neurology on 2/22/16, and dermatology on 4/21/16.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show orders were written for all relevant recommendations, including follow-up appointments, for the following: Individual #297 for cardiology on 4/1/16, Individual #182 for ophthalmology on 5/3/16, and Individual #92 for neurology on 2/22/16.

<table>
<tr><td colspan="12">Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.</td></tr>
<tr><td colspan="3">Summary: The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.</td><td colspan="9">Individuals:</td></tr>
<tr><td>#</td><td>Indicator</td><td>Overall Score</td><td>474</td><td>2</td><td>297</td><td>242</td><td>452</td><td>182</td><td>515</td><td>503</td><td>92</td></tr>
<tr><td>a.</td><td>Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.</td><td>28%
5/18</td><td>1/2</td><td>0/2</td><td>1/2</td><td>0/2</td><td>1/2</td><td>1/2</td><td>1/2</td><td>0/2</td><td>0/2</td></tr>
<tr><td colspan="12">Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #474 – cardiac disease, and weight; Individual #2 – respiratory compromise, and constipation/bowel obstruction; Individual #297 – aspiration, and osteoporosis; Individual #242 – GI problems, and weight; Individual #452 – respiratory compromise, and other: hypothyroidism, and hypothermia; Individual #182 – GI problems, and osteoporosis; Individual #515 – aspiration, and UTIs; Individual #503 – GI problems, and cardiac disease; and Individual #92 – aspiration, and weight).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #474 – cardiac disease, Individual #297 – osteoporosis, Individual #452 – other: hypothyroidism, and hypothermia, Individual #182 – GI problems, and Individual #515 – UTIs. The following provide a few examples of concerns noted regarding medical assessment, tests, and evaluations, as well as the identification of the necessary treatment(s), interventions, and strategies:

• For Individual #2, the diagnosis of dysphagia was not listed in the Active Problem List. The OT updated the PNMP, dated 8/5/15, with additional information concerning the technique to be used to ensure safety when the individual's mouth is rinsed during oral care. There was ongoing concern related to reflux and aspiration, but there was no evaluation to determine if reflux was a significant concern. There was no study completed to determine if gastroparesis was present. Two esophagogastroduodenoscopies (EGDs) were considered normal. One EGD indicated a normal mucosa, but given the individual's history of aspiration, it was unclear why other testing was not considered and/or completed to determine whether or not there was intermittent severe reflux. Whether the lower esophageal sphincter was patulous was not indicated in the EGD reports. The individual had 13 episodes of vomiting, but there was no further evaluation of these events (e.g., contribution of vertigo with change of position, medications that potentially contributed, etc.). Whether monitoring occurred to ensure the individual was properly positioned in the chair and bed could not be determined. The PCP did not attend the ISP to discuss this high risk.

• Individual #242 had a long history of gastritis, gastric ulcers, esophagitis, and esophageal ulcers (both proximal and distal). In the past, he had Barrett's esophagus, but there was no mention of this in the report from the most recent EGD. He was</td></tr>
</table>

prescribed Pantoprazole. He had not been known to have GI complaints, making early diagnosis difficult. In the submitted documents, there was no mention of whether or not causes of gastric acid hypersecretory states were considered or ruled out. His Active Problem List also did not include the diagnosis of gastroesophageal reflux disease (GERD), which caused confusion with the IDT. It was placed on his PNMP recently. There was no discussion of the contribution of pica to his GI pathology other than requiring surgery in the past.

In addition, during a prolonged hospitalization complicated by surgery and pneumonia, Individual #242 lost 20 percent of his weight. While hospitalized, he was taken off Clozaril. He was then offered a 6400-calorie diet excluding adlib snacks, and rapidly regained weight into the recommended weight range. Despite the fact that he had regained his prior weight, his diet did not appear to change. No documentation was submitted related to the need to reduce intake and/or how the IDT would accomplish this once he had become accustomed to large amounts of calories. It was unclear whether or not the IDT had considered or planned for the potential impact on his behavior. The impact on pica was not mentioned in that constant snacking was used to reduce the tendency toward pica. There also was no mention that he was at high risk for metabolic syndrome with the prescribing of Clozaril.

- Individual #297 had severe dysphagia, gastrostomy-tube (G-tube) feeding, reflux necessitating a fundoplication, GERD treated with Lansoprazole, gastroparesis treated with Erythromycin, as well as orders for respiratory therapy, and numerous medication treatments. In April 2016, the gastroenterologist recommended further radiologic study for GERD, if there were ongoing concerns of acid reflux. In July 2016, the individual was hospitalized for aspiration pneumonitis, but this recommendation was not further pursued to ensure reflux was not a contributing factor.

- Individual #503 had a challenging clinical course recently, necessitating her return to ABSSLC from the community. Prior to her transition to the community, in 2015, she developed gallstones, and her gall bladder was removed. She then had bouts of gallstone pancreatitis with emesis. There was no information that she was evaluated further or referred to a specialist for preventive treatment options. Shortly into her community placement, she again had vomiting and aspirated. In retrospect, the vomiting was not evaluated and treated at ABSSLC prior to discharge. There was also the long history of GERD, yet under the aspiration pneumonia section in the AMA, the PCP indicated that there was no evidence of GERD, which was confusing to anyone reading the AMA. Historically, she responded to improvement in GERD with the use of a proton pump inhibitor, yet upon her return, this was not a medication in her regimen. It was unclear when this had been stopped: while residing in the community, or while hospitalized. Stopping this medication could have initiated or aggravated her GERD and led to vomiting. Her dysphagia challenged her ability to clear her oral cavity of emesis, and aspiration would be a predictable/potential event. There was no evaluation to ensure she did not have gastroparesis.

- Individual #515 had undergone evaluation and treatment over time, including placement of a G-tube, placement of jejunostomy-tube (J-tube), and fundoplication. ENT and pulmonary consultants were involved in her care. The most recent ENT consultation recommended further ENT consultation if aspirations occurred, but there were three subsequent episodes of aspiration without further ENT consultation. The PCP or a covering PCP also wrote orders for the wrong medication route. Orders were placed in which the G-tube route was ordered instead of the J-tube, when there was information that the J-tube should be used for all medication. On 7/11/16, Individual #515 died at the age of 51 with causes of death listed as aspiration

pneumonia and chronic aspiration from dysphagia.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. Although documentation often was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs, the Monitoring Team will continue to review this indicator until IHCPs include necessary action steps and they are implemented.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	88% 14/16	1/1	2/2	2/2	1/1	2/2	2/2	1/2	2/2	1/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed generally were implemented. The exceptions were for Individual #515 for whom documentation was not present to show that the PCP followed through on the action step to "ensure the ENT [Ear, Nose, and Throat] consult and recommended follow ups are completed," and for Individual #92 for whom evidence was not present to show the PCP conducted monthly weight monitoring.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	Not rated (N/R)									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: Given the timely completion of QDRRs at Abilene SSLC (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), and timely practitioner review (Round 9 – 96%, Round 10 – 92%, and Round 11 - 96%), indicators a and c will be placed in the category of requiring less oversight. The Pharmacy Department should focus on improving the quality of the QDRRs., including but not limited to ensuring that recommendations are made, as appropriate. The Monitoring Team will continue to review the Center's implementation of agreed-upon recommendations.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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;	61% 11/18	0/2	2/2	2/2	1/2	1/2	2/2	0/2	1/2	2/2
	ii. Benzodiazepine use;	100% 4/4	N/A	2/2	N/A	2/2	N/A	N/A	N/A	N/A	N/A
	iii. Medication polypharmacy;	100% 10/10	2/2	2/2	2/2	N/A	2/2	N/A	N/A	2/2	N/A
	iv. New generation antipsychotic use; and	0% 0/4	N/A	0/2	N/A	0/2	N/A	N/A	N/A	N/A	N/A
	v. Anticholinergic burden.	29% 4/14	0/2	0/2	0/2	0/2	0/2	N/A	N/A	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.	94% 17/18	2/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 6/6	2/2	2/2	N/A	2/2	N/A	N/A	N/A	N/A	N/A
d.	Records document that prescribers implement the recommendations	N/A									

	agreed upon from QDRRs.										
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: b. At times, the Pharmacy Department did not review the most recent lab results, and/or did not further review abnormal or serial lab results to determine significance followed by recommendations, if clinically appropriate.

The five risks of metabolic syndrome were often not reviewed in the QDRRs, nor did the Pharmacist make recommendations based on risk findings.

Despite moderate to high anticholinergic activity/burden, which the Pharmacy Department identified, recommendations often were not made to address this finding.

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

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.

Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 474	2	297	242	452	182	515	503	92
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4	0/1	N/A	N/A	0/1	N/A	0/1	N/A	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	25% 1/4	0/1			0/1		1/1			0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/4	0/1			0/1		0/1			0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/4	0/1			0/1		0/1			0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/4	0/1			0/1		0/1			0/1

Comments: a. and b. Individual #2, Individual #297, Individual #452, Individuals #515, and Individual #503 were at low risk with regard to dental health. The Monitoring Team reviewed four individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

Although the goals/objective for Individual #182 was measurable, because it was not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For Individual #474, Individual #242, Individual #182, and Individual #92, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services. Individual #2, Individual #515, and Individual #503 were in the core group, so a complete review was completed for them as well. For Individual #297, and Individual #452, 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.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	Individuals have no diagnosed or untreated dental caries.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	N/A	N/A	1/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	67% 2/3	1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	0/1
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	50% 1/2	N/A	N/A	N/A	0/1	N/A	1/1	N/A	N/A	N/A
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: a. and b. Individual #2, Individual #515, and Individual #503 were edentulous.

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

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: The Center's scores for these indicators varied over the last two reviews. Although it was good to see high scores for most of the indicators during this review, all of these indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	N/A	N/A	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 6/6	1/1		1/1	1/1	1/1	1/1			1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	83% 5/6	1/1		1/1	1/1	0/1	1/1			1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	67% 2/3	0/1		1/1	1/1	N/A	N/A			N/A
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	80% 4/5	0/1		N/A	1/1	1/1	1/1			1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 2/2	1/1		N/A	1/1	N/A	N/A			N/A
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	N/A		N/A	1/1	N/A	N/A			N/A
Comments: Individual #2, Individual #515, and Individual #503 were edentulous. Overall, it was good to see that with few exceptions the Dental Department, in concert with IDTs, had implemented treatment and care for the individuals reviewed to assist them in maintaining optimal oral hygiene.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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	N/A									

	provided.										
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
	Comments: a. through c. None of the individuals whom the Monitoring Team reviewed had dental emergencies within the six months prior to the review.										

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: Work was needed to ensure that the IHCPs of individuals requiring suction tooth brushing include measurable strategies, IDTs implement the strategies, monitoring occurs to ensure the quality of the technique, and ISP monthly reviews includes specific data reflective of the measurable strategies.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	50% 2/4	N/A	0/1	N/R	N/A	N/R	N/A	1/1	0/1	1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	67% 2/3		0/1					1/1	N/A	1/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3		0/1					0/1	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% 0/3		0/1					0/1	N/A	0/1
	Comments: For Individual #297, and Individual #452, who were in the outcome group and were at low risk for dental, some indicators were not assessed. a. It appeared Individual #2 received suction tooth brushing. However, it was not included in the IHCP as a measurable strategy. Although it appeared an order was written for suction tooth brushing for Individual #503, the IHCP/ISPA did not address it. The order was recent, and so it was too soon to evaluate implementation.										

Outcome 9 – Individuals who need them have dentures.	
Summary: Given that over the last two review periods and during this review, individuals reviewed with missing teeth generally had an assessment to determine the appropriateness of dentures, including clinically justified recommendations (Round 9 – 100%, Round 10 – 100%, and Round 11 - 89%), Indicator a will move to	Individuals:

the category of requiring less oversight.											
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: For Individual #92, the replacement priority section was blank.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained an area on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. The quality of acute care plans also needs improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	58% 7/12	0/1	1/1	2/2	0/2	2/2	0/1	0/1	1/1	1/1
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	44% 4/9	1/1	0/1	1/2	0/2	1/2	1/1	N/A	N/A	N/A
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	25% 3/12	0/1	0/1	1/2	0/2	1/2	0/1	0/1	0/1	1/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	100% 2/2	N/A	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A

e.	The individual has an acute care plan that meets his/her needs.	0% 0/12	0/1	0/1	0/2	0/2	0/2	0/1	0/1	0/1	0/1
f.	The individual's acute care plan is implemented.	8% 1/12	0/1	0/1	1/2	0/2	0/2	0/1	0/1	0/1	0/1

Comments: The Monitoring Team reviewed 12 acute illnesses and/or acute occurrences for nine individuals, including Individual #2 – impaired skin integrity on 4/29/16; Individual #297 – asthma on 7/8/16, and impaired skin integrity on 3/21/16; Individual #242 – pinworms on 4/22/16, and bilateral community acquired pneumonia on 2/12/16; Individual #452 – hypothermia on 2/11/16, and aspiration pneumonia on 6/16/16; Individual #182 – change in level of consciousness on 7/1/16; Individual #515 - UTI on 4/28/16; Individual #503 – status post gastrostomy tube on 6/30/16; and Individual #92 – tinea (ringworm) on 4/4/16.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #474 – otitis media and sinusitis on 4/11/16, Individual #297 – asthma on 7/8/16, Individual #452 – aspiration pneumonia on 6/16/16, and Individual #182 – change in level of consciousness on 7/1/16.

c. The individuals with acute illnesses/occurrences that were treated at the Facility for which licensed nursing staff conducted ongoing nursing assessments were for Individual #297 – asthma on 7/8/16, Individual #452 – aspiration pneumonia on 6/16/16, and Individual #92 – tinea (ringworm) on 4/4/16.

d. The hospitalizations or ED visits for which licensed nursing staff conducted pre- and post-hospitalization assessments were those for Individual #297 – asthma on 7/8/16, and Individual #452 – aspiration pneumonia on 6/16/16.

e. Common problems with the acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs (the exceptions were Individual #297 – asthma on 7/8/16, Individual #242 – bilateral community acquired pneumonia on 2/12/16, Individual #452 – hypothermia on 2/11/16, and Individual #503 – status post gastrostomy tube on 6/30/16); alignment with nursing protocols (the exceptions were Individual #297 – asthma on 7/8/16, and Individual #452 – hypothermia on 2/11/16); specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions (the exception was Individual #92 – tinea on 4/4/16, but the goal was not measurable); clinical indicators nursing would measure (the exceptions were Individual #242 – bilateral community acquired pneumonia on 2/12/16, and Individual #452 – hypothermia on 2/11/16,); and the frequency with which monitoring should occur (the exceptions were Individual #242 – bilateral community acquired pneumonia on 2/12/16, and Individual #452 – hypothermia on 2/11/16).

f. The acute care plan that was implemented was for Individual #297 – asthma on 7/8/16. Some of the assessments that nurses documented in the IPNs were of higher quality than what the acute care plan required (e.g., for Individual #297 – asthma on 7/8/16, Individual #452 – aspiration pneumonia on 6/16/16, and Individual #92 – tinea on 4/4/16).

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

- For Individual #474 – otitis media and sinusitis on 4/11/16, an IPN noted that his right ear canal could not be assessed, because the nurse could not find any otoscope covers. Looking in the ear with an otoscope is an essential part of an assessment for complaints of an earache. In the acute care plan, there was no mention of assessing his tympanic membranes (both right

and left). Based on review of IPNs, inconsistency was noted in nurses' assessment criteria and nurses did not complete assessments twice daily as noted in the acute care plan.

- For Individual #2 – impaired skin integrity on 4/29/16, the acute care plan did not include even basic components, such as the frequency of assessments, or criteria for assessing an open area to the skin that were in alignment with current nursing guidelines. As documented in IPNs, ongoing assessments did not include measurements of the skin opening, except on the initial assessment and on the Nurse Practitioner's assessments, in order to determine progress of healing. Assessments were not consistently conducted, and there were no assessments from 5/16/16 through 5/19/16, when the issue was noted as resolved in the IPNs without an assessment of the area.
- Although the PCP saw Individual #297 on 3/21/16 for impaired skin integrity, no documentation was present to show that nursing staff contacted the PCP. The acute care plan did not include even basic components, such as the criteria for assessing a skin integrity issue that were in alignment with current nursing guidelines. Based on review of IPNs, assessment criteria were not consistent between nursing assessments. For example, the PCP only noted skin lesions on the individual's left arm, but an IPN, dated 3/23/16 at 6:00 a.m., noted drainage to right arm. It was unclear if new lesions were present or if the nurse wrote about the wrong arm. Similarly, IPNs noted dressing to the right arm and others noted dressing to the left arm. The healing process could not be determined from the IPNs. On 3/28/16, the PCP ordered ointment to arm for eight more days. Previous IPNs did not include descriptions of the lesions to support the need or not for additional ointment for healing.
- On 4/26/16, the laundry staff called to report that pinworms were seen in a bowel movement on a pad from home 6330. However, no documentation was found that nursing staff conducted an assessment of Individual #242 to determine if he had any signs and/or symptoms of pinworms.
- The acute care plan for Individual #452's aspiration pneumonia from which she returned from the hospital on 6/16/16, identified the baseline assessment and initiation date as 2/8/16. This appeared to be the incorrect acute care plan.
- When Individual #182 experienced a level of consciousness change on 7/1/16, nursing staff conducted an assessment that was not consistent with generally accepted practice. For example, the nurse did not document and/or complete a neurological check, and did not assess mental status. The assessment included vital signs, noted slurred speech, indicated the individual was unable to put on her pants and shoes, and stated she was "acting strange." Nursing staff did notify the PCP, who saw her within 30 minutes. She was admitted to the Infirmary. The acute care plan was also not consistent with generally accepted practice. It did not include neurological checks or mental status assessments. It did state to assess "level of response every eight hours." What was meant by "level of response" was unclear, and for this individual, eight-hour checks were not frequent enough.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2

b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	28% 5/18	2/2	0/2	1/2	0/2	0/2	1/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #474 – weight, and behavioral health; Individual #2 – falls, and respiratory compromise; Individual #297 – respiratory compromise, and polypharmacy/side effects; Individual #242 – dental, and weight; Individual #452 – hypothermia, and weight; Individual #182 – dental, and behavioral health; Individual #515 – urinary tract infections (UTIs), and cardiac disease; Individual #503 – constipation/bowel obstruction, and weight; and Individual #92 – cardiac disease, and dental).

The goal that was clinically relevant was the tooth brushing goal/objective for Individual #182 – dental.

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 #474 – weight, and behavioral health; Individual #297 – respiratory compromise; Individual #182 – behavioral health; and Individual #503 – constipation/bowel obstruction.

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

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

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

#	Indicator	Overall Score	Individuals: 474	2	297	242	452	182	515	503	92
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/18	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 specific risk areas for nine individuals, and as available, the IHCPs to address them.

a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

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

Summary: During the last review, as well as this review, the Center did well with the indicators related to administering medications according to the nine rights (c), documenting the use of the PRN medications (e, and previously d), and following infections control practices (g, and previously f). However, given the importance of these indicators to individuals' health and safety and the fact that if nurses were following the nine rights, the MAR variances would not be as numerous as they are, the Monitoring Team will continue to review them until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.

#	Indicator	Overall Score	Individuals: 474	2	297	242	452	182	515	503	92
a.	Individual receives prescribed medications in accordance with applicable standards of care.	44% 7/16	1/2	1/2	1/2	1/2	0/1	1/2	0/1	1/2	1/2
b.	Medications that are not administered or the individual does not accept are explained.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 7/7	1/1	1/1	1/1	1/1	N/A	1/1	N/A	1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with	13% 1/8	N/A	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1

	his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.										
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	20% 2/10	N/A	1/2	1/2	N/A	0/1	N/A	0/1	0/2	0/2
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	83% 5/6	0/1	1/1	1/1	N/A	1/1	N/A	N/A	1/1	1/1
f.	Individual's PNMP plan is followed during medication administration.	57% 4/7	1/1	0/1	1/1	1/1	N/A	0/1	N/A	0/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 7/7	1/1	1/1	1/1	1/1	N/A	1/1	N/A	1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of seven individuals, including Individual #474, Individual #2, Individual #297, Individual #242, Individual #452 (no observation), Individual #182, Individual #515 (deceased so no observation), Individual #503, and Individual #92.

a. and b. Problems noted included:

- The Medication Administration Records (MARs) for Individual #2, Individual #297, Individual #242, Individual #452, Individual #182, Individual #515, and Individual #92 showed omissions and/or MAR blanks for which variance forms were not provided.
- For Individual #474, multiple blocks on the MARs were circled without explanation for why the medications were not given.
- Individual #503's July MAR had the number of times per day combined two separate physician's orders regarding Senna syrup was to be administered. Since the physician's order had changed, the order should have been rewritten on the MAR.

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 medication observations, nurses conducted lung sounds for Individual #2, Individual #297, Individual #503, and Individual #92. However, IHCPs for the applicable individuals did not include respiratory assessment at the frequency necessary to address the needs of these individuals at high risk for aspiration.

e. Nursing staff did not note Individual #474's reaction or the effectiveness of the PRN medication administered on 6/3/16.

g. It was positive that for the individuals observed, nursing staff followed infection control practices.

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

i. Except for Individual #515, when a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation was not present to show individuals were monitored for possible adverse drug reactions.

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

l. and m. As noted above, numerous MAR blanks and circled boxes on MARs were not explained and no medication variance forms were submitted for them.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.	
Summary: Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. In addition, it was concerning that often IDTs did not refer individuals meeting criteria for PNMT review and/or assessment to the PNMT and/or that the PNMT did not	Individuals:

self-refer these individuals. These indicators will remain in active oversight.											
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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% 0/10	0/2	N/A	0/1	N/A	0/1	0/2	0/1	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	80% 8/10	2/2		1/1		0/1	2/2	1/1	1/1	1/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/10	0/2		0/1		0/1	0/2	0/1	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/10	0/2		0/1		0/1	0/2	0/1	0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/10	0/2		0/1		0/1	0/2	0/1	0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	38% 3/8	N/A	1/2	0/1	1/2	0/1	N/A	0/1	1/1	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8		0/2	0/1	0/2	0/1		0/1	0/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	13% 1/8		1/2	0/1	0/2	0/1		0/1	0/1	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/8		0/2	0/1	0/2	0/1		0/1	0/1	
	v. Individual has made progress on his/her goal/objective; and	0% 0/8		0/2	0/1	0/2	0/1		0/1	0/1	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/8		0/2	0/1	0/2	0/1		0/1	0/1	
Comments: The Monitoring Team reviewed 10 goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: falls, and weight for Individual #474; falls for Individual #297; skin integrity for											

Individual #452; choking, and aspiration for Individual #182; skin integrity for Individual #515; skin integrity for Individual #503; and weight, and aspiration for Individual #92.

a.i. and a.ii. 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: falls, and weight for Individual #474; falls for Individual #297; choking, and aspiration for Individual #182; skin integrity for Individual #515; skin integrity for Individual #503; and weight for Individual #92.

b.i. The Monitoring Team reviewed eight areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: weight, and aspiration for Individual #2; aspiration for Individual #297; weight, and aspiration for Individual #242; aspiration for Individual #452; aspiration for Individual #515; and aspiration for Individual #503.

These individuals should have been referred or to the PNMT, or the PNMT should have made a self-referral:

- On 12/2/15, Individual #2 had an aspiration event. During this time, the PNMT was following her for weight loss. Other than a quick mention in the minutes of the event, there was no substantive discussion of the event and the possible need for additional assessments. OT consults that occurred post-event focused only on adaptive equipment and did not provide assessment of oral functioning.
- Individual #297 had a history of aspiration pneumonia as well as other respiratory issues. However, when on 2/19/16, he was diagnosed with pneumonia, there was no evidence the PNMT reviewed him, even though the PNMT RN identified the need to review him and determine the need for services.
- Individual #242 was appropriately referred to the PNMT for weight loss issues. However, in February 2016, he was diagnosed with bilateral pneumonia. This was mentioned as a brief one-line statement in the PNMT minutes, but no additional evidence was submitted of discussion or review. Individual #242 was at high risk of aspiration, was losing weight, and coughing during meals. Based upon multiple indicators pointing towards the potential for the bilateral pneumonia to be connected to aspiration, at least a thorough PNMT review was warranted.
- On 2/25/16, Individual #452 was diagnosed with acute respiratory failure, and on 3/18/16 and 6/15/16, she was diagnosed with aspiration pneumonia, but the IDT and/or the PNMT did not evaluate her.
- Individual #515 had a history of aspiration pneumonia and respiratory issues. On 5/5/16, she was diagnosed with aspiration pneumonia. Upon her return from the hospital, the PNMT RN conducted a post-hospital review, but there was no evidence that the PNMT thoroughly discussed her and /or documented a clinical justification for not adding her to their caseload and conducting an assessment. On 7/11/16, Individual #515 died at the age of 51 with causes of death listed as aspiration pneumonia and chronic aspiration from dysphagia.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for the individuals reviewed. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: weight for Individual #2.

a.iii. through a.v, and b.iv. through b.vi. Overall, the lack of clinically relevant, achievable, and measurable goals meant that IDTs could

not measure meaningful outcomes for individuals. On a positive note, QIDPs had begun to include some data related to individuals' IHCP goals/objectives in their monthly reviews. The need to succinctly summarize and analyze the data remained, and without clinically relevant goals/objectives, the data could not yet be used to measure individuals' progress. However, as IDTs improve the quality of the goals and objectives in IHCPs, this practice of collecting and listing related data in the monthly reviews will provide a good start to IDTs' measurement of progress or lack thereof. Due to the current inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

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

Summary: These indicators will remain in active oversight.

#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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	1/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	20% 2/10	0/1	1/2	0/1	1/2	0/1	N/A	0/1	0/2	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.	20% 1/5	N/A	1/2	N/A	0/2	N/A	N/A	N/A	0/1	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were those for weight for Individual #2, and falls for Individual #297.

b. The following summarizes positive findings related to IDTs' responses to changes in individuals' PNM status:

- When Individual #2 experienced a change in status with regard to weight, the IDT met to discuss diet texture tolerance and the need to adjust the method of oral hygiene due to the loss of swallow function.
- When Individual #242 experienced a change in status with regard to weight, the IDT met frequently to review weight status as evidenced by the QIDP monthly notes and initiated the request for a sensory evaluation.

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

Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and

address them.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	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.	25% 1/4
	Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during two out of nine observations (22%). Staff followed individuals' dining plans during nine out of 28 mealtime observations (32%). Transfers were completed correctly two out of three times (67%).	

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: The Center had not made progress on this indicator.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
	Comments: a. As noted above, in 2001, Individual #297 received recreational/pleasure feeding, but no explanation/rationale was documented as to why this was discontinued. In 2005, the last Modified Barium Swallow Study (MBSS) showed severe issues, but no aspiration or penetration. The IRRF only stated that the IDT had no plan to resume oral intake due to severe dysphagia.										

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, IDTs did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	20% 2/10	1/1	0/1	0/1	1/2	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	10% 1/10	1/1	0/1	0/1	0/2	0/1	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	0/1	0/2	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/10	0/1	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The goal/objective that was clinically relevant and achievable, as well as measurable was the bathing SAP for Individual #474. Individual #242's bathing SAP was clinically relevant, but it was not time-bound. c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For the nine individuals, full reviews were conducted.											

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/10	0/1	0/1	0/1	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.	N/A									
Comments: None.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.	
Summary: Given that during the last review and during this review, individuals observed generally had clean adaptive equipment (Round 9 – no observations, Round 10 – 94%, and Round 11 - 86%) that was in working order (Round 9 – no observations, Round 10 – 89%, and Round 11 - 91%), Indicators a and b will move to the category of requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – no observations, Round 10 – 71%, and Round 11 - 63%), this indicator will remain in active oversight. During future reviews, it will also be	

important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	159	393	2	478	206	320	31	64	138
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	86% 30/35	1/1	1/1	2/2	1/1	2/2	1/1	2/2	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	91% 32/35	1/1	1/1	2/2	1/1	2/2	1/1	2/2	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	63% 19/30	0/1	0/1	0/2	1/1	1/2	0/1	1/2	1/1	0/1
		Individuals:									
#	Indicator		347	503	519	51	336	253	361	492	349
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		418	97	544	262	484	377	395	429	452
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/2	1/1	1/1	0/1	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.		2/2	0/1	1/1	0/1	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.		2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
		Individuals:									
#	Indicator		432	497	54	182					

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		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					
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		N/A	N/A	N/A	N/A					

Comments: a. The Monitoring Team conducted observations of 35 pieces of adaptive equipment. The adaptive equipment that was not clean included Individual #347's wheelchair, Individual #51's helmet, Individual #492's palm protector, Individual #418's adapted dining chair, and Individual #262's eyeglasses.

b. It appeared that a heavy backpack had potentially damaged the back of Individual #347's wheelchair, and was having a negative impact on the support the chair provided and increased the risk of pressure points on the individual's back. The straps of Individual #97's footstool were worn and not holding to the legs of the chair. This resulted in the footstool sliding under the dining chair, and, therefore, it did not provide the needed support.

c. Based on observation of Individual #159, Individual #2, Individual #320, Individual #31, Individual #138, Individual #347, Individual #503, and Individual #519 in their wheelchairs, and Individual #206 in his recliner, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors. In addition, Individual #393 and Individual #2's gait belts were positioned slightly below their breasts.

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

This Domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition, and communication. None of these indicators will be moved to the category of requiring less oversight.

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

Given that most ISPs did not yet contain personal goals and action plans that met the various criteria, the indicators related to progress were also not met. For the goals that met criterion with indicator 1, there were not consistent reliable data available to assess progress.

Skill acquisition plans existed for each individual, but they were inadequate in terms of content, quality of implementation, and review. Reliable data were available for just three of the SAPs; none were progressing.

Abilene SSLC measured engagement in some sites, but not yet all sites. The facility also had goals for engagement, which were met for about half of the individuals. This corresponded somewhat with observations by the Monitoring Team, which also found about half of the individuals to be engaged in activities.

Three individuals attended public school. The facility had a good working relationship with the Abilene public school district, but needed to do more work to ensure that school and home services were integrated in a manner that supported the individual (and that met the criteria for this single indicator).

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

IDTs did not have a way to measure clinically relevant outcomes with regard to individuals' communication skills. In addition, areas that require significant focus are on ensuring individuals' AAC/EC devices are available in all appropriate settings, individuals use them functionally, and staff are able to describe and demonstrate the use of AAC/EC devices in relevant contexts and settings, and at relevant times.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that goals were not yet individualized and did not meet criterion with ISP indicators 1-3, the indicators of this outcome also did not meet criteria. The handful of goals that were developed were not implemented and/or not reviewed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	474	2	570	225	452	297			
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 did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

For the goals that met criterion with indicators 1 and 2, none met criteria for indicator 3, that is, there were not consistent reliable data available to assess progress.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: Staff at Abilene SSLC interacted with individuals in a respectful, patient, and kind manner. The specific requirements of these indicators, however, were not met and both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	474	2	570	225	452	297			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
40	Action steps in the ISP were consistently implemented.	0%	0/6	0/6	0/6	0/6	0/6	0/6			

		0/6									

Comments:
39. Staff were basically knowledgeable regarding individual's risks and support needs. Observed interactions with individuals during the week of the review were very positive. Staff were generally respectful, patient, and kind. It was not possible, however, to confirm that staff were competent to implement their ISPs due to the overall lack of data supporting implementation.

40. Consistently documented implementation of all action plans was not found.

Skill Acquisition and Engagement

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

Summary: The facility was unable to demonstrate progress, in part, due to inadequate data collection. Even so, actions were usually not taken when an individual was not making progress. It was, however, good to see that IDTs were using whatever data they did have to help inform decision making about their SAP programming. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 95	530	93	570	2	554	474	222	225
6	The individual is progressing on his/her SAPS	0% 0/26	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	36% 5/14	1/2	1/1	1/3	0/1	N/A	1/2	0/1	1/2	0/2
9	Decisions to continue, discontinue, or modify SAPs were data based.	100% 26/26	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	2/2

Comments:
6. Although reliable data were reported for three SAPs (see skill acquisition indicator 5), progress was not evident for any of these programs. The facility reported that there was progress in nine SAPs for Individual #95 (counseling cards), Individual #530 (baking and setting the table), Individual #570 (greeting others and using an alarm), Individual #554 (designated location in the home), Individual #474 (blood pressure cuff and money management) and Individual #222 (making a schedule). Due to the lack of reliable data, however, these SAPs were rated as not progressing.

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

8. There was evidence of action planned or taken for five of 14 SAPs in which progress was not noted. This included a change in the training day (Individual #95 – counseling cards), retraining of staff (Individual #530 – greeting), getting feedback from staff regarding

barriers to implementation (Individual #93 – bathing), and requesting help from the home supervisor (Individual #554 – walk around others, and Individual #222 – exercise). When two of three monthly reviews included the same recommendations, a zero rating was provided because this suggested a lack of implementation (Individual #93 – accu-check and pedestrian safety, Individual #554 – vending machine, Individual #474 – bathing, Individual #222 – laundry). Individual #225 had a SAP for training at the diner, although the implementation date was December 2015, this had not been introduced as staff had not yet been trained on food handling practices. A recommendation to modify the current step was provided for Individual #225's baking SAP, but there was no evidence that this was completed until two months later.

9. There was evidence that decisions to continue, discontinue, or modify SAPs were data based in all 26 plans that were implemented.

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: SAPs were missing many components; none had all of the required components, including the absence of positive consequences for correct responding. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
13	The individual's SAPs are complete.	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:
13. None of the 27 SAPs that were reviewed included all of the required elements. The most consistent problem was with the identified consequence for correct responding. Praise was provided, but individual-specific reinforcers were not identified. Exceptions included when the individual could consume the food he had prepared (Individual #95, Individual #225), received a token (Individual #570, Individual #554, Individual #474), or some tangible item (Individual #93, Individual #222). Staff are advised to ensure that appropriate reinforcers are identified and applied in a way that are respectful of the individual's age (e.g., Individual #530 was to have stickers applied to his shirt or stamps placed on his arm or hand). Schedules, including number of trials, were often limited. In some cases, plans for generalization addressed maintenance of the skill rather than expansion of the skill to other environments or more advanced programs. Lastly, although documentation was generally appropriate to the SAP, Individual #95's learning to identify appropriate behaviors through review of visual cards did not indicate how one data point could be recorded to document his response to as many as 38 cards.

Outcome 5- SAPs are implemented with integrity.											
Summary: Correct implementation of SAPs must be ensured. SAPs that were observed by the Monitoring Team were not done correctly and the facility had not implemented a plan to regularly assess the quality of implementation. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225

14	SAPs are implemented as written.	0% 0/5	0/1	0/1	0/1	N/A	N/A	N/A	0/1	0/1	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.	12% 3/26	1/3	1/3	0/3	0/3	0/3	0/3	0/3	1/3	0/2

Comments:

14. The Monitoring Team was able to observe SAP implementation for five individuals, Individual #95, Individual #530, Individual #93, Individual #474, and Individual #222. While none were implemented as described in the SAP, there were some very commendable performances by staff. The individual working with Individual #95 on his counseling cards was very supportive and provided Individual #95 ample opportunity to respond. The nurse who completed the accu-check SAP with Individual #93 and the blood pressure SAP with Individual #474 did an outstanding job. She approached both individuals calmly and quietly, used appropriate forms of communication, and was quick to provide positive feedback. The staff working with Individual #530 at the workshop and Individual #222 in her home were both positive in their interactions. The problems with SAP implementation related to the use of incorrect discriminative stimuli or incomplete application of identified reinforcers. In Individual #530's case, it was concerning that his communication device was not readily accessible until the staff member handed this to him.

15. The facility 's policy is to conduct monthly monitoring of SAPs in the activity centers and work sites. As of May 2016, monthly monitoring of one SAP per individual is to occur in the home. As discussed with the facility staff, the expectation if for each SAP to be monitored a minimum of one time within a six-month period. Documents provided indicated that SAP monitoring had occurred for three of the 26 SAPs that had been implemented. These SAPs addressed Individual #95's working, Individual #530's greeting others, and Individual #222's exercising.

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

Summary: These two indicators received high scores on this review and indicator 17 also had a high score on the previous review. However, given that the indicators related to SAP data and SAP implementation integrity were far from meeting criteria, these two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 95	530	93	570	2	554	474	222	225
16	There is evidence that SAPs are reviewed monthly.	100% 26/26	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	2/2
17	SAP outcomes are graphed.	96% 25/26	3/3	3/3	3/3	3/3	2/3	3/3	3/3	3/3	2/2

Comments:

16. There was evidence that data-based reviews of all 26 of the implemented SAPs occurred monthly.

17. Graphic displays of data were provided in the SAP Progress Report by Week for 25 of 26 SAPs. The exception was Individual #2 for

whom no graph was provided for her going to work SAP. In most cases, correct trials were identified only when the person responded independently. Staff are advised to ensure that all measures depicted in the graphs correspond to the data recorded on the data sheets. Errors were found in 15 SAPs (Individual #95 – counseling cards, Individual #530 – all reviewed SAPs, Individual #93 – accu-check and bathing, Individual #570 – all reviewed SAPs, Individual #554 – designated location and walking around others, Individual #474 – bathing, and Individual #222 – all reviewed SAPs).

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

Summary: It was good to see that Abilene SSLC had goals for engagement, however, engagement was not regularly measured for most individuals. Goals, however, were not achieved for most individuals and observations by the Monitoring Team found about half of the individuals to be engaged in activities. This outcome and its indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
18	The individual is meaningfully engaged in residential and treatment sites.	56% 5/9	0/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	33% 3/9	0/1	0/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1
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.	56% 5/9	0/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1

Comments:

18. The Monitoring Team directly observed all nine individuals multiple times in various settings during the onsite visit. Active engagement was observed the majority of the time for five individuals: Individual #93, Individual #570, Individual #554, Individual #474, and Individual #222. Staff are advised to review the programs provided to the school-age individuals in particular as they are provided one-to-one staffing. Their days could be better structured with more active learning occurring in the home and elsewhere on campus. As both Individual #570 and Individual #474 attend school part-time, this is even more critical for them.

It is important to note the changes observed for Individual #93 since the Monitoring Team last reviewed her program. During this review, she was observed communicating with staff in her home (both direct support and nursing professionals) and work site. She was enjoying a meal at home while cooperating with the nurse who implemented a SAP. She was also advocating for herself as she finished her work before heading home after a morning shift.

For Individual #95 and Individual #2, staff are advised to review their work preferences with consideration given to varied situational assessment to determine whether a different job resulted in better participation.

19. This indicator is scored at 33% because engagement was assessed monthly in the home for the three school-aged individuals. Because they did not attend workshop, the limited assessment of engagement in workshop/day programs did not impact the Monitoring Team's scoring of this indicator for them. For the others six individuals, engagement was not assessed per guidelines in either their home and/or work site. That is, the facility provided evidence that engagement was assessed monthly in the homes for three of them. The exceptions were the homes in which Individual #93, Individual #222, and Individual #225 resided. Engagement was assessed five times in each of these homes over a six-month period. Over this same period of time, engagement was assessed one to four times in each of the three work centers.

20. Engagement goals had been established for all homes, work sites, and activity centers. Goal levels ranged from 75% to 90% in the homes in which the nine individuals resided, and were established at 90% in each of the work centers.

21. When engagement was assessed, the established goal levels were met in the homes and work environments serving five individuals (Individual #93, Individual #570, Individual #554, Individual #474, Individual #222).

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: It was good to see that community recreational activity goals were set, and met, for some individuals, and that training in the community occurred for a few individuals. The facility should build upon this so that all individuals have these opportunities. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	95	530	93	570	2	554	474	222	225
22	For the individual, goal frequencies of community recreational activities are established and achieved.	33% 3/9	0/1	0/1	1/1	0/1	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.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1

Comments:
22. Three individuals (Individual #93, Individual #554, Individual #225) had established goal frequencies for community recreational activities that had been achieved. Others participated in community activities at least monthly, but either did not have established goals (Individual #95, Individual #570, Individual #474) or the specific goals were not achieved (Individual #530, Individual #222). For Individual #530, whose ISP meeting was held in October 2015, it was determined in July 2016 that the movies on the hill began too late at night for him to attend. For Individual #222, whose ISP meeting was held in September 2015, it was determined in July 2016 that she was not interested in three of the four activities that had been identified. Individual #2's new ISP had just been introduced, but a review of the first full month indicated neither of her community-based activities had occurred.

23. Community-based SAP training had occurred for only Individual #554 and Individual #474 over a six-month period.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.												
Summary: The facility had a good working relationship with the local public school. Some, but not all, of the components required for this indicator were met. With additional attention, they likely can be. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	570	554	474							
25	The student receives educational services that are integrated with the ISP.	0% 0/3	0/1	0/1	0/1							

Comments:
25. Three of the individuals reviewed (Individual #570, Individual #554, Individual #474) were enrolled in school. There was evidence that both the home manager and BCBA attended the IEP meetings for all three individuals. For each individual, there was evidence that inclusion and an extended school year were discussed at the IEP meeting. Facility staff accompanied all three individuals to school each day.

The attendance sheets showed that the QIDP was present at Individual #474's meeting only. The ISPs for Individual #570 and Individual #554 only included action plans related to school. No evidence was found that the IDT reviewed school progress reports.

It was concerning that, when interviewed, the QIDP did not indicate that there were ongoing meetings between facility and school staff. Further, there was no evidence that skills addressed at school were generalized or reinforced (e.g., through homework) in the home environment.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.												
Summary: For the individual reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including	0%				0/1					

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

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: The Center had made no progress on these indicators. They will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
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	1/1	0/1	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	1/1	1/1	1/1	0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
	Comments: a. and b. The goals/objectives that were clinically relevant, as well as measurable were Individual #182's goal/objective related to conversational exchanges, and Individual #92's goal/objective related to maintaining a topic of conversation. c. through e. For the nine individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.										

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	474	2	297	242	452	182	515	503	92
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	38% 3/8	0/1	N/A	0/1	0/1	0/1	0/1	1/1	1/1	1/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Evidence was not present to show that the strategies were implemented, or that they were implemented at the frequency required.											

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: Areas that require significant focus are on ensuring individuals' AAC/EC devices are available in all appropriate settings, individuals use them functionally, and staff are able to describe and demonstrate the use of AAC/EC devices in relevant contexts and settings, and at relevant times. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]			Individuals:								
#	Indicator	Overall Score	105	544	93	485	104	374	533	203	312
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	40% 6/15	1/2	0/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	7% 1/15	0/2	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
			Individuals:								
#	Indicator		150	185	166	138	542				
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	0/1	1/1	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	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% 0/4
Comments: a. and b. It was concerning that often individuals' AAC devices often were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.		

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, earlier this year, the Center just had begun to take on additional post-move monitoring responsibilities, and was beginning to follow individuals in the community for a year as opposed to 90 days.

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

Although some supports in the CLDP reviewed were measurable, more work was needed in this area. Although IDTs included a number of important pre- and post-move supports, a number of essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff.

It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed. The Center should focus on IDTs following up in a timely and thorough manner when the Post-Move Monitor notes problems with the provision of supports.

Both individuals reviewed experienced Potentially Disrupted Community Transitions (PDCT), including return of one individual to the Center, and teams' reviews of PDCTs were not thorough.

Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.	
Summary: Although some supports in the CLDP reviewed were measurable, more work was needed in this area. Although IDTs included a number of important pre- and post-move supports, a number of essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement	Individuals:

Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.											
#	Indicator	Overall Score	192	503							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments:

1. The respective IDTs developed 12 pre-move supports for Individual #192 and 17 pre-move supports for Individual #503. For both individuals, the pre-move supports primarily focused on in-service training and ensuring that environmental and equipment requirements were in place. Many did not meet criterion for measurability. For both individuals, there were no descriptions of the training methodologies or competency demonstration criteria specified for the training supports, and the evidence columns called only for a copy of a competency test.

The Monitoring Team could also not confirm some of the environmental and equipment requirements met criterion for measurability. For both individuals, supports called for having a device at home to modify food texture to pureed, beds at specific degrees of incline, and wheelchair accessible environments. For these supports, visual verification was required as evidence, but it was not clear who was to make that assessment and whether that person was qualified to make such a determination. No evidence was available to document Habilitation Therapies staff had participated in any of these assessments for Individual #192. For Individual #503, it was noted Habilitation Therapies staff had examined the bathing apparatus and visited the home on 5/27/16 to assess the environment regarding the specific supports described above. When such evidence was requested, ABSSLC responded that no formal documentation of environmental assessment of the homes and day programs was available. Further, the Center reported that Habilitation Therapies staff had informed the Admissions and Placement Department that they are not authorized to do formal assessments on locations outside of ABSSLC. It is unclear whether or not this is an accurate interpretation, and if it is, what specifically prevents them from doing so. The Center should take action to clarify what role Habilitation Therapies will play in ensuring supports are available as required in pre-or post-move reviews. It is unreasonable to require a Post-Move Monitor to make an assessment that a more qualified Habilitation Therapies staff is not allowed to complete. However, if Center Habilitation Therapies staff are not permitted to conduct such assessments, the State will need to identify an alternative to ensure individuals' needs are met.

The respective IDTs developed 31 post-move supports for Individual #192 and 43 post-move supports for Individual #503. For both individuals, supports for training new staff were not measurable because they had no competency demonstration requirements. Many of the remaining supports were measurable. It was also positive that in many supports additional detail was provided to further explain the expectations.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs.

a. Past history, and recent and current behavioral and psychiatric problems: For both individuals, ISPs and assessments documented there were no significant history or need in this area, and the CLDP reflected this.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: For both individuals, the respective IDTs had developed

many supports related to safety, medical, healthcare, therapeutic, risk, and supervision needs that were addressed across settings, but this was not consistent. Examples included:

- For Individual #192:
  - There was no specific support to have a recliner, per her preference, although provider training referenced her feet should be elevated when so positioned. There was also an addendum regarding other positioning supports when in the recliner that were not referenced.
  - A support was identified for use of the Vagus Nerve Stimulator (VNS) to be included in the pre-move training, but there was no evidence staff received specific training in its use. The support called for her to have one with her at all times, but did not require any specific staff knowledge or competency in its use.
  - Both the Medical and Nursing assessments strongly emphasized, in all capital letters, that Individual #192 should not have various types of diathermy, but no support was identified.
  - No specific support was identified for staff knowledge related to side effects of medication other than that pre-move training would be provided. No specific methodology or specific competency demonstration was included.
  - The IDT did not identify supports that defined the level of nursing care, monitoring, and oversight required.
  - The IDT did not identify supports that defined any requirements for OT/PT monitoring of adaptive or mealtime needs.
- For Individual #503:
  - The IDT did not identify supports for staff knowledge related to supports for safety, medical, healthcare, therapeutic, risk, and supervision needs. Training supports for these areas did not include specific methodology or specific competency demonstration.
  - The IDT did not identify supports that defined the level of nursing care, monitoring, and oversight required.
  - The IDT did not identify supports that defined any requirements for OT/PT monitoring of adaptive or mealtime needs.

c. What was important to the individual:

- For Individual #192, the CLDP indicated what was important included having interaction with staff at both home and day habilitation; maintaining contact with family; maintaining good health and having a quieter home environment.

These were not consistently addressed. Examples included:

- The CLDP did not address having interaction with staff to any extent. Informal communication strategies did provide staff instructions as to how they could communicate effectively with her, and these were very positive, but there were no specific supports calling for social interactions or any particular activities with staff.

- Maintaining family contact was minimally supported, with the only support identified calling for the provider to contact the family within seven days to introduce themselves and ensure the family had contact information. There was no support for maintaining ongoing contact.

- Assessments and the ISP identified other personal preferences, such as her recliner, being read to, and pool activities. The IDT did not address these in supports.

- For Individual #502, the CLDP indicated what was important included staying healthy; getting attention from her staff; making new friends, and going out in the community. The CLDP included many supports related to maintaining her health, but did not address the remaining items to any extent. Informal communication strategies did provide staff instructions as to how they could communicate effectively with her, and these were very positive, but there were no specific supports calling for social interactions or any particular activities with staff. There were no supports related to making new friends and only one support for going out in the community, which was limited to a schedule of going out to eat or to shop at least once a month.

d. Need/desire for employment, and/or other meaningful day activities: The respective IDTs developed supports for both individuals that included training for day habilitation staff, specifications for the level of assistance and supervision at the day habilitation programs, as well as environmental requirements and adaptive equipment. Programmatically, meaningful day activities were limited to regular attendance at the day habilitation program Monday through Friday, with few supports for actual engagement in any meaningful activities. For Individual #503, the IDT specified only taking a one-hour nap daily and having access to hand-held items that make noise or keyboard. For Individual #192, the IDT specified only the opportunity to have a one-hour nap in the afternoon in the bed or recliner. The IDT did not address other recommendations from her assessments, which included using a switch to turn on radio, teaching her to place a sticker on the back of envelope to seal it, mailing her mother, and access to a pool per her preference.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success: For Individual #503, the IDT did address her preference for access to hand-held items and keyboard, which was positive. The IDT noted staff attention as being important to both individuals, but minimally incorporated this motivating factor into supports overall. Training supports for both individuals did include some very good informal communication strategies that would strengthen staff attention as a reinforcing or motivating component, but there were no specific supports for implementation of these.

f. Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs developed no supports related to teaching, maintenance, participation, and acquisition of specific skills.

- For Individual #192, the Functional Skills Assessment (FSA) recommended providing informal supports to call or mail her mother, the behavioral health assessment recommended skill acquisition to use a switch to turn on the radio and to teach her to place a sticker on the back of an envelope to seal it. No skill acquisition was recommended in the CLDP.
- For Individual #503, the FSA summary indicated, if only broadly, she would benefit from training in hygiene and all areas of dining. The IDT indicated only that no formal skill acquisition was recommended at this time, but with no justification provided.

g. All recommendations from assessments are included, or if not, there is a rationale provided: Recommendations from assessments were not consistently addressed. Examples included:

- For Individual #192, the following recommendations were not addressed: the FSA recommendations for mailing and/or calling her mother, having access to a pool, and the behavioral health recommendations for using a switch to turn on the radio and teaching her to place a sticker on back of an envelope to seal it. No justifications were provided.
- For Individual #503, the behavioral health assessment made several recommendations related to wearing headphones, pressing a button by the door to indicate a desire to go for a walk, and obtaining a work evaluation. These were not addressed in the CLDP and no justification was provided. The FSA noted she could benefit from skill acquisition in hygiene and all areas of dining, but the IDT indicated only that no formal skill acquisition was recommended at this time and provided no justification. Although the Recreation Discharge Summary offered no formal recommendations, it stated in the narrative that some activities had been "modified or altered to better suit her abilities," but provided no details as to these modifications.

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

Summary: It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed. Areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, and IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 192	503							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
4	Reliable and valid data are available that report/summarize the	0%	0/1	0/1							

	status regarding the individual's receipt of supports.	0/2									
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's scoring is correct based on the evidence.	50% 1/2	1/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A									
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A									

Comments:

3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes, included all locations where the individual lived or worked, were done in the proper format, and included comments regarding the provision of every support.

4. Reliable and valid data that report/summarize the status regarding the individual's receipt of supports were often, but not consistently, available. For Individual #192, the 24-hour awake staff support was to be confirmed by staff interview and observing a copy of the staff schedule, but there was no documentation included in the PMM checklist about a staff schedule. For Individual #503, there were several instances in which reliable and valid data were not provided. These included:
    - At the time of the 7-Day PMM review, it was noted that one of two hospital beds used to provide personal care was at 17 degrees and the other at 33 degrees. The Post-Move Monitor reminded staff that only the latter should be used for Individual #503, but there was no evidence she confirmed that this was their actual practice.
    - There was no documentation that home staff were interviewed about the support for prevention of hypothermia.
    - The Post-Move Monitor did not document whether the meal observed at home was pureed as needed.

5. Based on information the Post Move Monitor collected, neither of the individuals had consistently received supports as listed and/or described in the CLDP, as detailed below:

    - Individual #192 was not receiving a number of supports as required, particularly at the day program. These included: 1) none of the beds used for personal care had head of bed elevation as required; 2) no documentation indicating blood pressure was being taken prior to the administration of Lisinopril as required; 3) the bowel movement log could not be found at either the home or day program; 4) day program staff were not aware of the VNS and the seizure log was not in

place at home; 5) skin care products (Aloe Vesta) were not available at the day program, and there was no documentation at home or day program that skin care was being provided every two hours and with the required product; 6) there was no evidence of oral care being provided; 7) home staff were not aware of diet; 8) home staff were apparently not aware of fiber-stat requirement; unopened containers of fiber-stat were found, but the MAR indicated it was being administered; 9) day program staff were not familiar with mealtime protocols and the prescribed two handled cup was not available there; 10) the antimicrobial floor mat could not be found at the home; and, 11) the individual was not wearing needed knee-high compression socks at the day program.

- Individual #503 was not receiving a number of supports as required, without justification, including: 1) the correct size of sling was not available at the day program; 2) she was not receiving prune mash daily; 3) there was no documentation that prune juice was being given with each meal as required; 4) the home sent a lunch to the day program that was not pureed as needed and still had many lumps, which might also have been an indication that food was not being pureed appropriately for meals in the home; 5) the floor mat for beside her bed could not be located; 6) the home was using only one staff to transfer using the lift and for bathing, rather than the required two.

6. Based on the supports defined in the CLDP, the Post Move Monitor correctly scored based on the evidence in most cases, but not all. For Individual #192, the Post Move Monitor identified missing supports and scored appropriately. For Individual #503, two supports that called for elevation of bed for personal care at the day habilitation program were both marked as in place, but the Post Move Monitor reminded staff of this need rather than questioning staff about their practice. This would not support an affirmative rating.
7. When individuals were not receiving the supports listed/described in the CLDP, the IDT/Facility did not consistently implement corrective actions in a timely manner:
   - Individual #192 was not receiving a number of supports as described above with regard to Indicator #5. No ISPA meetings were held to involve the IDT in this discussion. The Post Move Monitor noted a two-week follow-up visit would be made and was completed, but the nature of the missing supports was such (in particular, positioning during personal care, awareness of VNS magnet, staff not aware of mealtime techniques and adaptive equipment, lack of required skin care) that this lapse of time was concerning. It required more immediate and assertive action and follow-up, including IDT involvement.
   - While the PMM took actions for identified concerns for Individual #503, these actions were not timely given the significant nature of the risks involved. Individual #503, who returned to the Center after experiencing two PDCT events, required emergency room care due to dehydration, constipation and a urinary tract infection (UTI) on 5/20/16. The IDT did not meet until 6/7/16 to review and discuss. The IDT identified at that time that she required strategies related to intake of fluids that had not been identified in the CLDP. Provider staff further indicated they were having difficulty getting her to accept all the fluids she was supposed to receive. The strategies known to the IDT included making sure she was fully awake and alert, adding flavoring to water, and taking time and being patient as it could take some time. After identification of these supports, provider staff were reported to have been in-serviced, per provider RN notes, but it was unclear that all staff were in-serviced. No documentation was available.
8. The Post Move Monitor was diligent in her efforts, but not all problems were followed through to resolution. In addition to the lack of documentation of in-service for strategies related to increasing fluid intake for Individual #503 described above, other documentation received of needed re-inservicing did not clearly indicate that staff were trained as to her pureed diet. Follow-up was needed to ensure this had taken place. For Individual #192, given the provider was experiencing significant problems with both individuals, follow-up should have been assertive to ensure resolution and not just in the form of paper compliance.
9. and 10. The Lead Monitor attended portions of the 90-day post-move monitoring visit for Individual #192. However, she was hospitalized at the

time. Therefore, the Lead Monitor did not observe the portions of the post-move monitoring activities that required observations of the individual. Although a full post-move monitoring was not observed, and therefore, these indicators were not rated, the Monitoring Team appreciates the Post Move monitors efforts to conduct reviews of all supports and services, and to continuously improve the process.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.											
Summary: Both individuals reviewed experienced PDCT, including return of one individual to the Center, and teams' reviews of PDCTs were not thorough. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	503							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	0% 0/2	0/1	0/1							

Comments:

11. Both individuals experienced multiple PDCTs. The IDT did not consistently take timely and assertive action to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.

- Individual #192 experienced four PDCT events.
  - The first occurred on 7/24/16 when she developed blisters on her hand, of unknown origin. The IDT met on 8/19/16 to review and determined this event could not have been anticipated and there was nothing that could have been done differently. This event resulted in a DFPS investigation for possible abuse. The investigation documented the blisters were of unknown origin and that paramedics had commented they did not appear to be thermal burns, but might be from an infection or insect bites. The allegation was unconfirmed. Documentation from the hospital appeared to support these conclusions.
  - On 8/25/16, Individual #193 fell off the wheelchair lift and was taken to the emergency room with an abrasion and a knot on her head. It was reported that provider staff did not follow proper procedures. On 9/16/16, the IDT reviewed this event.
  - At the 7/24/16 ISPA, the IDT noted the provider nurse would continue to follow up with the community primary care provider (PCP) regarding the discontinuation of UTI-Stat, the administration of which was a support in the CLDP due to her history of chronic and often asymptomatic UTIs. It was recommended the Post Move Monitor follow up at the time of the 90-Day PMM visit on 8/30/16. More prompt follow-up would have been in order if the IDT considered this to be an important preventative support. Of note, on 8/28/16, Individual #193 was taken to the emergency room and

diagnosed with a UTI. She returned to the home briefly, but was subsequently hospitalized on 8/29/16, and remained there at the conclusion of the monitoring visit. She was also diagnosed with a pressure ulcer to her heel and with an exacerbation of chronic obstructive pulmonary disease (COPD). Follow-up documentation ABSSLC provided indicated she was discharged on 9/6/16. On 9/16/16, the IDT reviewed this event as a PDCT. The IDT determined the UTI could have been anticipated, but the pressure sore and COPD diagnoses could not have been as she had no history of either. This was not the case as it related to the pressure sore. The IRRF noted that Individual #193 was at medium risk for skin integrity issues and had a history of altered skin integrity as recently as June 2015. At that time, she developed open sores to her buttocks, which were not staged as pressure sores, but did require supports. She did have a number of supports in this area while at the Center, according to her IRRF, including a gel foam mattress, repositioning every two hours, direct support staff to examine skin during daily bathing and personal care and report to nurse any open areas, redness or oozing. CLDP supports did not specifically address these needs, but should have.

- Individual #503 returned to the Center after experiencing two PDCT events. The timeliness and assertiveness of IDT responses overall was of concern given the nature of these risks.
  - The first event occurred on 5/20/16 in which the individual required emergency room care due to dehydration, constipation, and UTI. At the 7-Day PMM visit on 5/9/16, the Post Move Monitor correctly identified Individual #503 was not receiving prune mash at one meal per day as needed related to constipation, and requested staff to be re-inserviced. Evidence of this was not required until 5/16/16, and while some staff were trained immediately, others were not until 5/21/16, after her hospitalization. The IDT did not meet until 6/7/16 to review and discuss this PDCT. The team identified at that time that Individual #503 required strategies related to intake of fluids that were not identified in the CLDP. Provider staff indicated they were having difficulty getting her to accept all the fluids she was supposed to receive. The strategies known to the IDT included making sure she was fully awake and alert, to add flavoring to water and to take time and be patient. The Center was not able to provide evidence all staff had been re-trained.
  - Individual #503 was hospitalized again on 6/5/16 and diagnosed with pneumonia and sepsis. It was concerning that at the time of the 7-Day PMM visit on 5/9/16, home staff provided lunch foods that were not pureed as needed and day habilitation staff were not aware of the issue until the Post Move Monitor brought it to their attention. It was positive the Post Move Monitor identified this issue and asked for staff to be re-inserviced, but evidence of this training was not required until 5/16/17. Some staff were re-inserviced immediately, per the documentation provided, but some were not until 5/21/16. This was an issue that placed the individual at significant risk, and should have been addressed immediately for all staff. It was also not clear the in-service sufficiently addressed the risk. The documentation provided indicated re-training addressed "all meals pudding consistency," rather than on pureed consistency. Given the finding by the Post Move Monitor that a pureed diet was not being provided as required, immediate and assertive action was needed.

    In addition, as noted above with regard to Outcome #8 for medical, a number of concerns prior to her discharge impacted her post-discharge care, and evidence was not present to show that the IDT planned supports to address these issues and/or communicated necessary information to the community provider and medical team. More specifically, prior to her transition to the community, in 2015, Individual #503 developed gallstones, and her gall bladder was removed. She then had bouts of gallstone pancreatitis with emesis. There was no information that she

was evaluated further or referred to a specialist for preventive treatment options. Shortly into her community placement, she again had vomiting and aspirated. In retrospect, the vomiting was not evaluated and treated at ABSSLC prior to discharge. There was also the long history of GERD. Historically, she responded to improvement in GERD with the use of a proton pump inhibitor, yet upon her return, this was not a medication in her regimen. It was unclear when this had been stopped: while residing in the community, or while hospitalized. Stopping this medication could have initiated or aggravated her GERD and led to vomiting. Her dysphagia challenged her ability to clear her oral cavity of emesis, and aspiration would be a predictable/potential event. The PCP did not participate in the PDCT meeting, and the team did not discuss these potential factors in her unsuccessful community transition.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.											
Summary: Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	503							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	0% 0/2	0/1	0/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the	0% 0/2	0/1	0/1							

	individual.										
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	50% 1/2	1/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/0	0/0							
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	50% 1/2	0/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

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

- Assessments updated with 45 Days of transition: The Center did not review or update the IRRF for either of the individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process. Neither individual had an updated pharmacy assessment. Individual #192 last had a comprehensive OT/PT evaluation in 2012, but had experienced significant changes in mobility status since that requiring seven addenda, and had further required three addenda since her last dining evaluation. Given all these modifications, a current comprehensive evaluation would have been in order.

- Assessments provided a summary of relevant facts of the individual's stay at the Center: For Individual #192, nine of 11 assessments had a reasonable summary of stay. Those that did not included the OT/PT evaluation, as described above and the Nursing assessment, which was focused primarily on just the previous year rather than including her significant history. For Individual #503, eight of 11 assessments had a reasonable summary of stay. Examples of those that did not meet criterion included the Social assessment and the FSA. The Social assessment provided no detail about her life at the Center other than stating she enjoys interaction with staff and peers. The FSA had, as a summary of stay, a grid that identified two current skills she was working on, as well as four skills attempted in the past and for which her status had deteriorated. The instructions for this grid indicated it was important to include anything tried that presented difficulty for the person and should not be tried again, but no such detail was included. In the section entitled potential skill deficits identified for future training, the FSA indicated only very broadly that she would benefit from training in hygiene and all areas of dining.

- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: For Individual #192, training recommendations were not specific. For Individual #503, the social assessment recommendations were generic and did not set forth individualized supports and services needed to transition successfully. The FSA had only a broad recommendation that she would benefit from training in hygiene and all

areas of dining. The recreation assessment had no recommendations.

- Assessments specifically address/focus on the new community home and day/work settings: Assessment did not consistently meet this criterion. Examples included the recreation assessment for Individual #192, and the social assessment, FSA and recreation assessment for Individual #503.

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

- There was documentation to show IDT members actively participated in the transition planning process: It was difficult to evaluate the active IDT member participation in the transition process. The Center provided Monthly Reviews as ISPAs related to transition, but a review of these indicated there was seldom discussion related to transition in these documents. In one instance, for Individual #503, the review of the IHCP action plans indicated that she had a lowered body temperature when she returned early from a provider visit in March, but there was no indication the IDT discussed or engaged provider in discussion.

- The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed: ABSSLC staff were identified as being responsible for ensuring the implementation of supports for only five pre-move supports for Individual #192 and only three pre-move supports for Individual #503.

- The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting: Documentation indicated the IDT met with Individual #192 to review transition activities and the IDT arranged for three pre-move visits to the provider home, but did not indicate she attended the CLDP meeting. For Individual #503, documentation indicated the IDT met with her to review transition activities and that she attended the CLDP meeting, which was good to see.

14. Training was completed, but the documentation indicated there was no competency demonstration for key supports. For Individual #192, supports that did not have competency demonstration criteria included the pureed diet, use of the sling for transfers, use of the bathing apparatus and use of the VNS. Written testing was superficial and would not have been sufficient to document competence; for example, the only question about the VNS was that it is used for what issue, but there was no evidence staff were trained in its use or were competent to use it. For Individual #503, there was no competency demonstration required for the pureed diet or use of the sling for transfers. There were also no questions regarding either of these included in the written competency quiz. The Monitoring Team was also concerned the Center did not identify a need for, or have appropriate Center staff undertake, any re-training for provider staff for either of these individuals after the respective 7-Day PMM Checklists indicated a significant lack of competence in key support areas.

15. There was no evidence provided that Center staff collaborated with community clinicians to meet the needs of these two individuals, who both had significant health care and physical and nutritional management needs.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results. This was not found in either of the CLDPs reviewed. The PMM checklist for Individual #192 indicated that ABSSLC OT/PT staff attended the Pre-Move Site Review (PSMR) and made recommendations regarding both the bathing table and

doorsills, so this was considered to have met criterion. Documentation for Individual #503 did not provide any such evidence. As described under Indicator #1 above, the Monitoring Team was concerned about the report that Habilitation Therapies staff had informed the Admissions and Placement Department they are not authorized to do formal assessments on locations outside of ABSSLC. The Center should take action to clarify what role Habilitation Therapies will play in this regard.

17. In addition to some of the concerns documented in Indicators #14-16, the IDT should have, but did not, engage with provider staff to ensure competency to provide critical supports in the required manner after the 7-Day PMM visits for both individuals identified significant gaps in knowledge. For Individual #192, the IDT should have had heightened sensitivity to this need, given the difficulties this provider had with the implementation of similar supports prior to the hospitalization and readmission of Individual #503. Also for Individual #192, Transition Specialist documentation noted that the IDT had expressed concerns about whether the home could meet her needs shortly before transition took place and a meeting was to be held on 5/31/16 to discuss further. The Monitoring Team requested these minutes as evidence Center staff and provider staff collaborated to ensure her needs could be met, but no minutes were available. Transition staff indicated this meeting was held but was informal. Given the circumstances, the meeting should have been an ISPA that included LIDDA and provider staff.

18. Criterion was met for Individual #503. The LIDDA attended the CLDP and assisted in coordinating her return to Center. Participation was also documented in ISPAs related to the PDCTs. As noted above for Individual #192, the APC and transition department staff should have engaged LIDDA staff and others in a pre-transition ISPA regarding uncertainties about whether the selected home could meet her needs.

19. For Individual #192, PMSRs were completed on 5/27/16 and 6/3/16. Many supports were in place, but not all. Training had been completed, but documentation indicated there was no competency demonstration for key supports, including pureed diet, use of sling and bathing apparatus and use of VNS. Written testing was superficial; for example, the only question about the VNS was that it is used for what issue. No evidence was provided that staff were trained in its use or were competent to use it. For Individual #503, a PMSR occurred on 4/22/16. Most pre-move supports appeared to be in place at that time, but again training documentation indicated there was no competency demonstration for key supports, including pureed diet and the use of the sling for transfers. The written competency quiz also did not address either of these supports.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: It was positive that for the individuals reviewed documentation was present to show justifiable reasons for the delays in their transitions. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. This indicator will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	192	503								
20	Individuals referred for community transition move to a community setting	100%	1/1	1/1								

	within 180 days of being referred, or adequate justification is provided.	2/2									
Comments: For both individuals, transition exceeded 180 days, but Transition Specialist documentation indicated delays were justified resulting from individuals' needs.											

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
    - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - In the past six months, individuals with dental emergencies;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
    - Crisis intervention restraints.
    - Medical restraints.
    - Protective devices.
    - Any injuries to individuals that occurred during restraint.
    - DFPS cases.
    - All serious injuries.
    - All injuries from individual-to-individual aggression.
    - All serious incidents other than ANE and serious injuries.
    - Non-serious Injury Investigations (NSIs).
    - Lists of individuals who:
        - Have a PBSP
        - Have a crisis intervention plan
        - Have had more than three restraints in a rolling 30 days
        - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
        - Were reviewed by external peer review
        - Were reviewed by internal peer review
        - Were under age 22
    - Individuals who receive psychiatry services and their medications, diagnoses, etc.

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:
- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual’s transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

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

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

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