United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

Dates of Onsite Review: May 22nd to 26th, 2017

Date of Report: August 11, 2017

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

Table of Contents

Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Abilene SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

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

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management; abuse, neglect and incident management; pretreatment sedation/chemical restraint; mortality review; and quality assurance. At the time of the last review, nine of these indicators, including one entire outcome, had sustained high performance scores and moved to the category requiring less oversight. Presently, four additional indicators will move to the category of less oversight. These indicators are in the areas of restraint, incident management, and quality assurance/pharmacy. This includes the entirety of Outcome #3 related to restraint, and Outcome #4 related to quality assurance/pharmacy.

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 use of restraint at Abilene SSLC improved/decreased since the last review. Abilene SSLC had the third lowest census-adjusted crisis intervention restraint in the state. Also, lots of attention was paid to the use of pretreatment sedation medications, TIVA, and non-chemical restraint for dental procedures. Many formal and informal plans were in place. Individuals who were restrained received that restraint in a manner that followed state policy and generally accepted professional standards of care. The exceptions were that half of the restraints did not meet criteria for timeliness of restraint monitor arrival, and some problems were noted with nurses monitoring of restraints, as discussed below. All monitoring occurred, but monitors were late, some by a few minutes, some by a few hours. During onsite discussion, the facility's director of behavioral health services stated that they were aware of this and were addressing it.

An additional positive finding was that, in one case, restraint review detected that the restraint was applied improperly. Staff were retrained on the spot. This was a good practice to see implemented. The facility had an active restraint reduction committee.

Continued improvement was noted with regard to the Center's scores for the indicators related to nurses' monitoring of restraints. Center staff are encouraged to continue to focus on the following areas with regard to nursing restraint monitoring:

conducting timely and complete assessments of individuals' vital signs and mental status, following up on abnormalities as needed, and clearly documenting whether or not restraint-related injuries occurred.

Abuse, Neglect, and Incident Management

Abilene SSLC maintained performance on indicator 1 regarding supports having been in place to have reduced the likelihood of the incident occurring for all investigations, except one. That being said, it was the single facility investigation of a serious injury. This was identified in the last report as an area of concern (i.e., frequency and management of serious injuries). There were no individuals at Abilene SSLC who were deemed for streamlined investigations due to frequently making false allegations.

The facility showed good progress in improving reporting protocol compliance. The 78% score for this review was higher than the last two reviews when scores were around 30%. There was steady progress on the presence of the specific elements of an investigation and the collection and analysis of evidence. Alleged perpetrators were immediately re-assigned. In one case, however, the facility investigation did not name any alleged perpetrators whereas the DFPS investigation named alleged perpetrators. This was not reconciled and the alleged perpetrators were not re-assigned at that time.

Conduct of serious injury audits and non-serious injury investigations were not happening as required. Attention needs to be paid to these activities. Similarly, work on data analysis, trending, and action plan development was a continuing need.

Other

Regarding pretreatment sedation, IDTs were considering development of plans or whether they would be counter-therapeutic. For all of the cases the Monitoring Team reviewed, the IDT determined that a plan was not needed. Future monitoring reviews will look for instances where plans were called for.

It was good to see that the Center completed clinically significant DUEs, and conducted follow-up to recommendations. Given the Center's performance during this review and the last two reviews, this entire outcome will move to the category requiring less oversight.

Restraint

<table>
<tr><td colspan="2">Outcome 1- Restraint use decreases at the facility and for individuals.</td></tr>
<tr><td>Summary: The use of restraint at Abilene SSLC improved/decreased since the last review. Most of the measures showed decreasing trends, overall low occurrence, and/or improvement compared with the last review. Abilene SSLC had the third lowest census-adjusted crisis intervention restraint in the state. Also, lots of attention was paid to the use of pretreatment sedation medications, TIVA, and non-chemical restraint for dental procedures. Many formal and informal plans were in</td><td>Individuals:</td></tr>
</table>

place. These two indicators will remain in active monitoring for review at the next monitoring visit.											
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	83% 10/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	82% 9/11	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (July 2016 through March 2017) were reviewed. Overall, the census-adjusted frequency of occurrence of crisis intervention restraint was on a decreasing trend over the nine-month period, was lower than at the time of the last two reviews, and was now the third lowest in the state. The frequency of crisis intervention physical restraint followed the same pattern because all but four of the crisis intervention restraints were crisis intervention physical restraints. Moreover, the average duration of a physical restraint was less compared with the last two reviews and was the second lowest in the state. The frequency of crisis intervention chemical restraints was four, all for one individual during one week in January 2017, subsequent to surgery and medication changes. The frequency of crisis intervention mechanical restraints was zero.

The number of injuries that occurred during restraint was low; there were three occurrences over the nine-month period, all of which were non-serious. Fewer individuals had crisis intervention restraint applied that at the last review. It ranged from four to eight per month over the nine-month period, compare with eight to 12 at the time of the last review. No individuals had protective mechanical restraint for self-injurious behavior.

The facility paid a lot of attention to the use of restraint for dental procedures. There were no occurrences of non-chemical restraints. Regarding the use of pretreatment sedation medication and TIVA for dental procedures, in the past 12 months, 28 individuals and 53 individuals had these interventions, respectively. There were numerous formal and informal plans and strategies in place to reduce the need for these interventions. The facility reported that 47 individuals had some sort of plan and, further, the facility monitored progress and reported that most individuals were making some progress in this area. Data on usage was graphed and included in the dental department's quarterly QAQI Council report.

The facility also used pretreatment medication sedation and non-chemical restraint for implementation of various medical procedures. They reported usage for 19 individuals, all of whom had informal treatment strategies. This was good to see. The medical department, however, was not tracking or trending usage or determining progress. Two individuals had specialized medical restraint plans. Individual #482 had a medical restraint plan that was comprehensive that was for the administration of IM psychotropic medication following multiple refusals. The protocol was detailed, documented, and usage was graphed to show implementation over time (it was decreasing). For example, it was implemented three times in the nine-month period. Individual #93 had a medical restraint plan for administration of medication and lab work, also following a detailed protocol. It was used from one to 12 times per month. Trending of frequency was not, however, occurring to determine if usage was becoming more or less frequent over time.

Thus, facility data showed low/zero usage and/or decreases in 10 of these 12 facility-wide measures (overall use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; duration of physical restraint; restraint-related injuries; number of individuals who had crisis intervention restraint; use of PMR-SIB; use of non-chemical restraint and use of pretreatment sedation or TIVA for dental procedures.

The facility had an active restraint reduction committee. It meant once per month and reviewed data, discussed specific individuals, and put action steps into place. An active restraint reduction committee can play an important role in affecting the overall usage of restraint at a facility.

2. Four of the individuals selected for review by the Monitoring Team were subject to restraint. The Monitoring Team also reviewed a restraint for each of two additional individuals. Of these six individuals, five received crisis intervention physical restraints (Individual #487, Individual #530, Individual #482, Individual #95, Individual #446), one received crisis intervention chemical restraint (Individual #428), and one also received medical restraint (Individual #482). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for four of the six (Individual #487, Individual #530, Individual #428, Individual #446). The other five individuals selected by the Monitoring Team had no restraints making a total of 9 of the 11 individuals meeting the criteria for this indicator.

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

Summary: Good progress was seen, evidenced by five of the indicators scoring at 100%. With sustained high performance, these indicators might be moved to the category of requiring less oversight after the next review. Some documentation and content problems led to criterion not being met for two individuals for indicator 11. All of these indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 487	530	482	428	95	446			
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
7	There was no injury to the individual as a result of implementation of the restraint.	100% 7/7	1/1	1/1	2/2	1/1	1/1	1/1			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 7/7	1/1	1/1	2/2	1/1	1/1	1/1			

9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	100% 1/1	Not rated	Not rated	1/1	Not rated	Not rated	Not rated			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 7/7	1/1	1/1	2/2	1/1	1/1	1/1			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	71% 5/7	1/1	0/1	1/1	0/1	1/1	1/1			

Comments:
The Monitoring Team chose to review seven restraint incidents that occurred for six different individuals (Individual #487, Individual #530, Individual #482, Individual #428, Individual #95, Individual #446). Of these, five were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and one was a medical 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. Individual #482 had a medical restraint plan that described, in detail, the conditions under which physical restraint would be used in order for administration of bi-weekly psychotropic medication. Overall, the plan, rationale, and implementation were reasonable. Usage was six times in 12 months, that is, 23% of the time that medication was administered, restraint was used.

9. Because criterion for indicator #2 was met for four of the individuals, this indicator was not scored for them. One of the other two individuals had recently moved to another facility and, therefore, this indicator was also not rated for him.

11. For Individual #530, the ISP IRRF section stated that when restraint was necessary, the following safeguards must be used, but then nothing was written.

For Individual #428, the ISP IRRF section stated that "Based on conditions identified, the IDT determined restraints are contraindicated and must not be used." Likely, this was referring only to crisis intervention physical restraint, not to crisis intervention chemical restraint, but that was not specified in the ISP.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: This indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	487	530	482	428	95	446			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 3/3	Not rated	1/1	1/1	1/1	Not rated	Not rated			

Comments:
12. Because criteria for indicators 2-11 were met for three individuals, this indicator was not scored for them. Staff were unable to be

interviewed for Individual #446 because he recently moved to another facility. Staff who worked directly with the other three individuals were very familiar with restraint requirements and answered the Monitoring Team's questions correctly

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

Summary: These indicators will remain in active monitoring. The behavioral health services department was aware of the frequent lateness of restraint monitor arrival and said they would be addressing it. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	487	530	482	428	95	446			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	50% 3/6	0/1	0/1	1/1	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			

Comments:
13. The facility's Analysis of the Restraint form provided good documentation of restraint review. For instance, it included three specific recommended follow-up actions for Individual #487 1/28/17.

Three restraints did not meet criteria for timeliness of restraint monitor arrival. All occurred, but were late, some by a few minutes, some by a few hours. During onsite discussion, the facility's director of behavioral health services stated that they were aware of this and were addressing it.

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

Summary: Continued improvement was noted with regard to the Center's scores for the indicators related to nurses' monitoring of restraints. Center staff are encouraged to continue to focus on the following areas with regard to nursing restraint monitoring: conducting timely and complete assessments of individuals' vital signs and mental status, following up on abnormalities as needed, and clearly documenting whether or not restraint-related injuries occurred. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	487	530	482	428	95	446			

a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	57% 4/7	1/1	1/1	1/2	0/1	0/1	1/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	71% 5/7	1/1	1/1	1/2	0/1	1/1	1/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	57% 4/7	1/1	1/1	1/2	0/1	0/1	1/1			

Comments: The crisis intervention restraints reviewed included those for: Individual #487 on 1/28/17 at 3:05 p.m.; Individual #530 on 2/28/17 at 11:02 p.m.; Individual #482 on 11/23/16 at 1:56 p.m., and 3/9/17 at 9:18 p.m.; Individual #428 on 1/25/17 at 12:59 p.m. (chemical); Individual #95 on 12/24/16 at 7:53 p.m.; and Individual #446 on 1/16/17 at 11:38 a.m.

a. For six of the seven crisis intervention restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint, which was good to see. The exception was for Individual #482 on 11/23/16 at 1:56 p.m., for whom nursing staff documented the first vital signs and mental status at 3:48 p.m.

For five of the seven restraints, nursing staff monitored and documented vital signs. The exceptions were for:

- As noted above, Individual #482 on 11/23/16 at 1:56 p.m., for whom nursing staff documented the first vital signs at 3:48 p.m.
- Individual #95's restraint on 12/24/16 at 7:53 p.m., for which nursing staff documented no specific vital signs, just a notation that vital signs were within normal limits.

Nursing staff documented and monitored mental status of the individuals for four of the seven restraints. Examples of problems included:

- As noted above, for Individual #482 on 11/23/16 at 1:56 p.m., nursing staff documented the first mental status at 3:48 p.m.
- For Individual #428's chemical restraint on 1/25/17 at 12:59 p.m., after obtaining initial vital signs, nursing staff did not document the individual's mental status. The assessment of the individual's mental status is critical in assessing the effects of the chemical restraint.
- For Individual #95's restraint on 12/24/16 at 7:53 p.m., nursing staff documented no mental status.

b. and c. For individuals with incomplete vital signs or mental status, the Monitoring Team could not determine whether or not follow-up action was needed. In addition, for Individual #428's restraint on 1/25/17 at 12:59 p.m., nursing staff did not document whether or not any restraint-related injuries occurred. For Individual #482's restraint on 11/23/16 at 1:56 p.m., an IPN, dated 11/23/16 at 3:00 p.m., noted that the individual complained of her head hurting from banging it against a door on the right side. Nursing staff provided no indication regarding whether or not it was restraint-related. An IPN indicated: "Tylenol effective." However, there was no IPN indicating when the Tylenol was initially given.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: Performance on this indicator improved to 100% for the first time. This was good to see. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	487	530	482	428	95	446			
15	Restraint was documented in compliance with Appendix A.	100% 7/7	1/1	1/1	2/2	1/1	1/1	1/1			
Comments:												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: Restraint review should also be sure to focus on the important details of restraint implementation, such as restraint monitor time of arrival and correspondence with ISP IRRF contra-indications for restraint. Indicator 17 showed improvement from the last review. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	487	530	482	428	95	446			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	33% 2/6	0/1	0/1	1/1	0/1	1/1	0/1			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	80% 4/5	1/1	1/1	1/1	1/1	1/1	0/1			
Comments: 16. The reviews did not detect the late arrivals of the restraint monitors or the contra-indication for restraint in Individual #428's incident. For Individual #95 12/24/16, restraint review detected that the restraint was applied improperly. Staff were retrained on the spot. This was a good practice to see implemented.												

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: Criterion was met for the single occurrence reviewed. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall Score	428									
47	The form Administration of Chemical Restraint: Consult and Review	100%	1/1									

	was scored for content and completion within 10 days post restraint.	1/1									
48	Multiple medications were not used during chemical restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
49	Psychiatry follow-up occurred following chemical restraint.										

Comments:
47. Individual #428 had an episode of chemical restraint during this review period. The consultation and review documentation was completed within the allotted time frame.

Abuse, Neglect, and Incident Management

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

Summary: Abilene SSLC maintained performance on this indicator, meeting all criteria for all investigations, except one. That being said, it was the single facility investigation of a serious injury. This was identified in the last report as an area of concern (i.e., serious injury), and is also reflected in the facility's performance on indicators 10, 14, and 15. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	487	530	482	293	444	561	520	446	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	89% 8/9	1/1	1/1	1/1	1/1	1/2	1/1	1/1	1/1	

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

- Individual #487, UIR 2283, DFPS 44842385, unconfirmed allegation of physical abuse, 10/1/16
- Individual #530, UIR 2754, DFPS 44883860, inconclusive allegation of physical abuse, 10/11/16
- Individual #482, UIR 7388, DFPS 45149905, unconfirmed allegation of physical abuse, 2/12/17
- Individual #293, UIR 2542, DFPS 44856050, confirmed allegation of neglect, 10/1/16
- Individual #444, UIR 7701, DFPS 45162602, confirmed allegation of neglect, 2/20/17
- Individual #444, UIR 3010, leg fracture, 3/16/17
- Individual #561, UIR 8993, DFPS 45202238, unconfirmed allegation of verbal-emotional abuse, unknown date
- Individual #520, UIR 7587, discovered pelvic fracture, 2/15/17
- Individual #446, UIR 3809, unauthorized departure, 11/13/16

1. For all 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.

The facility maintained good performance on this indicator. Most of the investigations involved allegations of improper actions by staff for which there were no trends or prior occurrences related to the individual. For one investigation, Individual #444 UIR 3010, lack of always implementing his PNMP and PBSP were identified, resulting in the 0 score for that investigation.

There were no individuals at Abilene SSLC who were deemed for streamlined investigations due to frequently making false allegations.

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

Summary: The facility showed good progress in improving reporting protocol compliance. The 78% score for this review was higher than the last two reviews when scores were around 30%. Further, the two investigations that did not meet criteria were due to lack of explanation in the UIR, which if had been done, might have resulted in both of those also being scored as meeting criteria. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	487	530	482	293	444	561	520	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.	78% 7/9	1/1	0/1	1/1	1/1	1/2	1/1	1/1	1/1	

Comments:

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

Those not meeting 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 #530 UIR 2754: The DFPS report noted that the incident occurred at 8:10 am and was reported to them at 9:52 am. The UIR also noted that the incident occurred at 8:10 and was reported to the Center at 8:55 pm and reported to the facility director designee at 9:00 am. There was nothing in UIR that attempted to reconcile these data.
- Individual #444 UIR 7701: The DFPS report that the incident was reported to them on 2/21/17 at 8:55 am. According to the UIR, the incident was reported to the director at 8:30 am on 2/21/17. The serious injury occurred the day before, sometime in the afternoon. There was nothing in the UIR to describe these circumstances.

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: Criteria were met for all three indicators for all investigations. Due to sustained high performance, indicator 5 will be moved to the category of requiring less oversight. With sustained high performance, indicators 3 and 4 might also be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 487	530	482	293	444	561	520	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	Not rated	1/1	Not rated	Not rated	1/1	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 9/9	1/1	1/1	1/1	1/1	2/2	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% 9/9	1/1	1/1	1/1	1/1	2/2	1/1	1/1	1/1	

Comments:
3. Because indicator #1 was met for seven of the individuals, this indicator was not scored for them. The indicator was scored for the other two individuals and criteria were met.

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

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

#	Indicator	Overall Score	Individuals: 487	530	482	293	444	561	520	446	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	89% 8/9	1/1	1/1	1/1	1/1	2/2	1/1	0/1	1/1	

Comments:
6. While onsite, documentation was provided showing re-assignment of all alleged perpetrators for a number of the investigations. In the future, reassignment must be correctly and fully noted in the UIR because it is the official investigation report. For this review, the Monitoring Team accepted alternate documentation showing reassignment date and time.

One investigation, however, had other problems in providing immediate protections and, therefore, was scored as not meeting criteria:

- Individual #520 UIR 7587: Although the UIR showed no alleged perpetrators, the DFPS report identified two. There was no

indication that they were placed on no contact status.

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

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: Abilene SSLC showed steady progress on all three indicators across the last three reviews. With sustained high performance, all three might be moved to the category of requiring less oversight. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	487	530	482	293	444	561	520	446	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 9/9	1/1	1/1	1/1	1/1	2/2	1/1	1/1	1/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 9/9	1/1	1/1	1/1	1/1	2/2	1/1	1/1	1/1	
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)	89% 8/9	1/1	1/1	1/1	1/1	1/2	1/1	1/1	1/1	
Comments: 10. For Individual #444 UIR 3010, the UIR labeled the injury as having a determined cause, however, evidence did not support this. For example, there were no witnesses to what was assumed to be a fall. The UIR stated that the injury was likely caused from a fall, but there was no evidence to reach this conclusion.											

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: For Indicator 13, performance was about the same as at the last review, thus, more focus is still required. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	487	530	482	293	444	561	520	446	
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was										

	reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).										
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	67% 6/9	1/1	0/1	1/1	1/1	0/2	1/1	1/1	1/1	

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

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: Abilene SSLC continued to conduct serious injury audits, but date information needs to be included in the future. The conduct of non-serious injury investigations deteriorated in terms of performance. This indicator will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	487	530	482	293	444	561	520	446	
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	38% 3/8	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	

Comments:
14. Audit of serious injuries was not occurring as required in that audit reports did not include the time period that the audit covered. Policy requires a six-month period and the dates should be noted on the audit. Given that this criterion was clarified during the Monitoring Team's work with State Office over the past few months (i.e., since the time of the last review at Abilene SSLC), this indicator will remain in less oversight, however, this clerical item must be fixed going forward in order for this indicator to remain in this category.

15. For Individual #444, a non-serious injury investigation was required, and was done correctly. For Individual #530 and Individual #520, there were no non-serious injuries that warranted a non-serious injury investigation. For the other five individuals, there were one or more non-serious injuries that should have been subjected to a non-serious injury investigation.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: Performance was good on all three indicators, with one exception of an environmental safety action not occurring. Also, the state's recent policy when maintaining employment after a confirmation of physical abuse 2 was not followed. The facility, however, said this would be followed going forward. All three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	487	530	482	293	444	561	520	446	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 9/9	1/1	1/1	1/1	1/1	2/2	1/1	1/1	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 5/5	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	86% 6/7	1/1	N/A	1/1	N/A	1/2	1/1	1/1	1/1	
Comments: 17. There was one occurrence of a confirmation of physical abuse category 2 with employment maintained. The recent state office protocol was not followed. 18. Implementation of the recommendation for slip/grip tape for Individual #444 UIR 2011 was not done.											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. There was not much progress since the last review. This outcome and its indicators will remain in active monitoring. Assistance from the QA department would likely be helpful here.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	No									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No									
22	There was documentation to show that the expected outcome of the	No									

	action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.										
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									
Comments: 20-23. The facility reported that since implementation of the IRIS system, quarterly injury trend reports were not completed for quarter 4 of fiscal year 2016 and quarter 1 of fiscal year 2017. Overall, attention was needed to address these four indicators as per the criteria. For instance, quarterly reports contained three months of data with little or no reference how these data related to prior quarters. Therefore, there was not an assessment of whether things are improving or regressing. In addition, the QAQI council meeting minutes no longer contained follow-up information and, for the most part, re-stated the data presentation.											

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	N/A									
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered TIVA for dental work. b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.											

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Center's performance with this indicator had improved over the last three reviews (i.e., Round 9 – 0%, Round 10 – 80%, Round 11 – 100%, and Round 12 – 100%). If the Center sustains this performance, this indicator might move to the category requiring less oversight at the time of the next review.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212

a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. None.											

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: It was good to see that IDTs were considering development of plans or whether they would be counter-therapeutic. This is indicator 2 and with sustained high performance, it might be moved to the category of requiring less oversight after the next review. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	293	444	51						
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	67% 2/3	1/1	0/1	1/1						
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 3/3	1/1	1/1	1/1						
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A	N/A	N/A	N/A						
4	Action plans were implemented.	N/A	N/A	N/A	N/A						
5	If implemented, progress was monitored.	N/A	N/A	N/A	N/A						
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A						
Comments: 1. Three of the individuals had experienced pretreatment sedation over the previous 12 months. These three, Individual #293, Individual #444, and Individual #51, all had current Medical Restraint Plans. These included descriptions of observed behavior without the use of PTS, outlined the procedures for which PTS was approved, and provided recommendations for supports. Signed consent was provided by the Human Rights Officer for all three plans, and the plans for Individual #293 and Individual #51 (not Individual #444) had evidence of signed consent from either the LAR or facility director. 2. The IDTs for all three individuals determined that action plans would not be effective in reducing the future need for PTS.											

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	98	287	21	196					
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.	75% 3/4	1/1	1/1	0/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

Comments: a. Since the last review, nine individuals died, including two individuals who died the week before the Monitoring Team's onsite review. The Monitoring Team reviewed four deaths. Causes of death were listed as:

- On 8/10/16, Individual #98 died at the age of 61 of sepsis due to candida;
- On 9/21/16, Individual #287 died at the age of 46 of congenital heart disease with cardiomyopathy;
- On 9/28/16, Individual #21 died at the age of 49 of sick sinus syndrome, and coronary artery disease;
- On 12/16/16, Individual #112 at the age of 69 with causes of death pending;
- On 1/5/17, Individual #196 died at the age of 64 of azotemia, persistent anorexia, and advanced dementia;
- On 3/16/17, Individual #7 died at the age of 53 of aspiration pneumonia;
- On 4/2/17, Individual #83 died at the age of 41 of perforated duodenal ulcer, septic shock, and multi-organ system failure;
- On 5/18/17, Individual #485 died at the age of 68 with causes of death pending; and
- On 5/18/17, Individual #518 died at the age of 79 with causes of death pending.

b. through d. Although it appeared that the mortality reviews resulted in some valuable recommendations, none of mortality reviews

reflected a comprehensive review of the care provided to the individual. Some of the problems included:

- The Center provided a Nursing Death Review that included information for the following categories: Reporting Information (facility name and date), Demographic information, Active Problems, Summary of History, Recent Pertinent Assessments and Recommendations, Significant Recent Laboratory and Procedural and Diagnostic and Screening Findings, Clinical Factors, Preliminary Autopsy Findings, and Additional Clinically Related Information Provided by Staff. This report provided information, but did not include any type of analysis of care.
- The Center also provided the Quality Assurance (QA) Death Review of Clinical Services report that the QA Nurse completed, which contained essentially the same sections as in the Nursing Death Review. However, a number of consults and pages of IPNs for the past six months were included in the QA report.
- The Center provided another format for the Nursing Death Review that included information for the following categories: Reporting Information (facility name and date), Demographic information, Active Problems, Summary of History, Medications, Medications Administered by Facility 72 Hours prior to Death, Allergies, Hospitalizations, Recent Pertinent Assessments and Recommendations, Restraints prior to Death, Review of Medical Record, Acute Illness/Injury prior to Death (at least six months prior to death), Weights, Diet, Narrative of Events 72 Hours prior to Death, Clinical Factors, Preliminary Autopsy Findings, and Additional Clinically Related Information Provided by Staff. Similarly, this report provided information, but did not include an analysis of care.
- Although these reports included recommendations, often there were a number of additional findings noted in the reports without any corresponding recommendations found.
- In addition, the recommendations that were listed often were not written in a measurable manner.
- Also, there was little to no review of the actual care the individual received, especially from nursing staff.
- For Individual #196, there were additional discipline death reviews submitted including: Pharmacy, Behavioral Health Services, Dental, Habilitation Therapies, Nutritional, and a brief note that the psychiatrist wrote. However, none of these reports included a comprehensive review and analysis of the individual's care that the specific disciplines provided or a review of their assessments, IHCP goals/objectives, or action steps included in the IHCPs.
- Training addressing Root Cause Analysis and writing recommendations would be helpful in assisting staff responsible for mortality reviews to organize the information and data contained in a mortality reviews, and then to connect the recommendations to the analysis of these data. Also, adding specific components to the mortality report formats, such as a review of the IRRF, Acute Care Plans, IHCPs, quality and timeliness of assessments, etc. would help to ensure consistency in what documents staff reviewed.

e. Although some progress was noted with regard to including follow-up activities to assess the impact of the implementation of recommendations, a number of the recommendations were not written in a way that ensured that Center practice had improved. In addition, documentation was not provided to support completion of all recommendations, and at times, the documentation provided was well past the due date for completion.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: For the one individual reviewed who experienced an ADR in the six months prior to the review, Center staff identified and reviewed it, and took appropriate follow-up actions.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	ADRs are reported immediately.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	100% 1/1	1/1								
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 1/1	1/1								
d.	Reportable ADRs are sent to MedWatch.	100% 1/1	1/1								
Comments: a. through d. On 12/22/16, Individual #51 had elevated liver enzymes from Nitrofurantoin. After the medication was stopped, on 1/4/17, his levels returned to normal. On 2/21/17, the Pharmacy and Therapeutics Committee discussed this ADR, and decided to send it to MedWatch. The Center submitted documentation showing the information was sent to MedWatch.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: Given that during the last two review periods and during this review, the Center completed clinically significant DUEs (Round 10 – 100%, Round 11 – 100%, and Round 12 – 100%) and conducted follow-up to address recommendations (Round 10 – 100%, Round 11 – 100%, and Round 12 – 100%), Indicators a and b 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% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 2/2
Comments: a. and b. In the six months prior to the review, Abilene SSLC completed two DUEs, including: • In November 2016, a DUE on Prevnar 13 that was presented to the Pharmacy and Therapeutics (P&T) Committee on 2/21/17, for which follow-up was needed for 23 of the 61 individuals reviewed. The minutes of the May 17, 2017 P&T Committee		

meeting indicated: "In the Follow Up we achieved 98% compliance in reviewing the 23 individuals." Although compliance was high, the 98% was confusing. If one of the 23 was not in compliance, it would be 96%; and

- A DUE on statin use in individuals with diabetes ages 40 to 75 that was presented to the P&T Committee on 5/17/17, for which follow-up was not yet due at the time of the Monitoring Team's review.

In addition, the Center completed follow-up on two DUEs, including one in November 2016, on Topamax as follow-up to a DUE completed in August 2014; and one in November 2016, as follow-up to a DUE on intra-class polypharmacy for constipation completed in August 2016. The latter was used in calculating the score for Indicator b.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 15 of these indicators, including one entire outcome, in psychiatry, behavioral health, medical, nursing, and skill acquisition, had sustained high performance scores and moved to the category requiring less oversight. Presently, six additional indicators will move to the category requiring less oversight. These are in the areas of ISPs, psychiatry, psychology, and dental. Two indicators in the nursing area will move back to active monitoring.

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

Assessments

In less than half of the cases, the IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP. One of the IDTs arranged for and obtained needed, relevant assessments prior to the IDT meeting.

ISPs were revised annually, however, they were not implemented in a timely manner, and some aspects were not implemented at all. There was improvement in IDT member participation/attendance in the important annual meeting.

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

All of the individuals had a completed comprehensive psychiatric evaluation, but a number had incomplete content. The annual psychiatry update documentation was complete with one important exception regarding the interaction between one individual's anti-psychotic medication and an active seizure disorder. Overall, documentation regarding consent for psychotropic medication had improved greatly, though some needed more detail in the risk benefit discussion.

In psychiatry, personal goals are required for each individual that reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. It

was encouraging to see some progress along these lines. For instance, all of the individuals had identified target behaviors that were related to their psychiatric disorder. In most cases, it was physical aggression, though there were some related to depression and hostility ratings.

In behavioral health services, the data system did not provide reliable data. For instance, data timeliness was assessed over eight-hour blocks of time, and several plans had a change in data collection with questions noted regarding data accuracy.

It was concerning that most individuals reviewed had not received timely annual medical assessments.

Five of the nine individuals had quality annual medical assessments that included the necessary components and addressed individuals' needs. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care for each active medical problem, when appropriate.

For this review and the last two reviews, the Dental Department completed timely dental summaries for the individuals reviewed. As a result, the related indicator will move to the category requiring less oversight. For this review, the Dental Department also completed timely dental exams for the individuals reviewed. The Center should continue to focus on improving the quality of the dental exams and summaries.

Due to previous high performance with regard to the completion of new admission and annual nursing reviews and physical assessments, the related indicators moved to the category requiring less oversight. However, based on the annual nursing assessments the Monitoring Team used for other elements of its review, problems were noted with regard to the completion of complete physical assessments, including weight graphs, fall assessments, assessments of reproductive systems, and, in some cases, Braden scores. As a result, these indicators will move back to active oversight. It appeared that these issues related to the conversion to IRIS. The State Office Nursing Discipline Lead is working to make the necessary changes.

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.

It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. This was an improvement from the last review when the Center's score was 17% for the related indicator. In addition, since the last review, the scores during this review showed improvement with regard to timely referral of individuals to the PNMT, and timely review. The Center should focus on sustaining or continuing its progress in these

areas, as well as improving completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments.

The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has been consistently low. The quality of OT/PT assessments also continues to be an area on which Center staff should focus.

It was good that IDTs reviewed and made changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually, and included functional descriptions of individuals from an OT/PT perspective in their ISPs. Although assessments did not identify all of the necessary strategies, interventions, and programs necessary to meet individuals' OT/PT needs, IDTs often included those strategies that were identified in individuals' ISPs/IHCPs, which was also positive.

It was good to see improvement with regard to the timeliness of communication assessments, as well as the completion of the correct type of assessment (i.e., an update versus a comprehensive communication assessment). However, significant work was needed to improve the quality of the communication assessments.

Individuals continued to have SAPs that were measurable. Their basis in assessment, practicality, functionality, and meaningfulness needed a lot of improvement.

Individualized Support Plans

The development of individualized, meaningful personal goals was not yet at criteria, but much progress was evident. All six ISPs, for instance, included two or more goals that met criteria, and one ISP had goals that met criteria in four of the six areas, for a total of 17 goals that met criteria. Further, all 17 of these goals were written in measurable terms. Unfortunately, none were implemented sufficiently, correctly, and with adequately collected data to determine progress.

Regarding action plans to support achievement of the personal goals, the 11 indicators in outcome 3 were not met. These indicators refer to the full set of action plans. That is, the qualities that are being monitored by these indicators may be evident in different action plans within the set of goals and action plans for the individual.

There was no longer any use of exclusionary timeout and use of the respite home had decreased and was under much improved guidelines for implementation and monitoring. PBSP content continued to improve. Aspects of the PBSP content that requires focus are described in the report below.

IDTs met monthly to review supports and progress towards goals. This was good to see, however, there was little evidence that IDTs also met when a serious incident occurred or a trend of incidents was identified (e.g., multiple falls, emesis, peer-to-peer

aggression). When recommendations were made or supports were revised, IDTs rarely met again to ensure recommendations were implemented. Reliable and valid data were often not available to guide decision-making.

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.

Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines.

ISPs

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

Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but much progress was evident as described below. All six ISPs, for instance, included two or more goals that met criteria, and one ISP had goals that met criteria in four of the six areas, for a total of 17 goals that met criteria. This was very good progress since the last review. Further, all 17 of these 17 goals were written in measurable terms, also demonstrating good progress. Unfortunately, none were implemented sufficiently, correctly, and with adequately collected data to determine progress. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	428	487	8	435	172			
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	2/6	4/6	2/6	3/6	3/6	3/6			
2	The personal goals are measurable.	0% 0/6	2/6	4/6	2/6	3/6	3/6	3/6			
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 #51, Individual #428, Individual #487, Individual #8, Individual #435, Individual #172). 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.

None of the six individuals had individualized goals in all six areas, however, there was improvement in the development of individualized goals based on preferences in some of the six areas.

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

- Individual #51's goals for greater independence and living options.
- Individual #428's goals for leisure/recreation, relationships, greater independence, and work/day programming.
- Individual #487's goals for work/day programming, and living options.
- Individual #8's goal for relationships, living options, and greater independence.
- Individual #435's goals for leisure/recreation, relationships, and greater independence.
- Individual #172's goals for recreation/leisure, relationships, and greater independence.

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

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

- Individual #51's recreation goal to select his activity of choice and his work/day goal to participate in at least one activity.
- Individual #428's living option goal to live at Abilene SSLC was not aspirational.
- Individual #487's greater independence goal to use his Dynavox was not based on his preferences. Per IDT discussion, he consistently refused to use his Dynavox.
- Individual #8, Individual #435, and Individual #172's work/day goals were based on compliance rather than skill building or preferences.

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

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

3. None of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. As noted throughout this report, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of data and documentation provided by the facility. It appeared that few action plans were regularly implemented.

The facility reported that QIDPs and other team members were participating in additional training offered by the state office on ISP development. The training was focused on assessments, SAP development, and overall implementation. Hopefully, this will assist the IDTs in developing more functional goals that will support individuals to learn new skills based on their preferences. In addition, the facility had implemented a cross team procedure to review preference and strength assessments prior to the ISP.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.

Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators refer to the full set of action plans. That is, the qualities that are being monitored by these indicators may be evident in different action plans within the set of goals and action plans for the individual. Of these 11 indicators, four showed improvement (albeit it slight) and one showed a decrease. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	428	487	8	435	172			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	1/6	0/6	0/6	2/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	33% 2/6	1/1	0/1	0/1	0/1	1/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

	health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.										
14	ISP action plans integrated encouragement of community participation and integration.	33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6	0/1	1/1	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% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	1/6	0/6	0/6	2/6			

Comments:

8. Some personal goals did not meet criterion in the ISPs, as described above in indicator 1, therefore, those action plans could not be evaluated in this context. A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

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

For the 17 personal goals that met criterion under indicator 1, three had action plans that were likely to lead to the accomplishment of the goal. IDTs were struggling with developing action steps that would lead to measurable progress towards goals. The three goals that met criteria with this indicator were Individual #487's school/day goal, and Individual #172's recreation and relationship goals (they were the same).

9. Two of six ISPs (Individual #51, Individual #435) integrated preferences and opportunities for choice in the individuals' ISP action plans.

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

11. While five of six individuals had goals that might lead to greater independence, action plans did not support accomplishment of these goals.

12. IDTs did not fully integrate strategies to minimize risks in ISP action plans. Specific support strategies should be included in staff instruction for implementing action plans, when relevant, to minimize risks in all settings. Further discussion regarding the quality of

strategies to reduce risks can be found throughout this report. Some examples where strategies were not integrated in the ISP included:

- Individual #51's IDT did not integrate PNMP strategies into other action plans and supports. The PNMT did not reassess his support needs following a significant change of status.
- Individual #428's support strategies to reduce his risk for falls were not well integrated into his ISP. The PNMT had recommended a walker to minimize his risk for falls. The walker was discontinued without replacing supports or reassessing his risk.
- Individual #487's behavior support strategies were not integrated into action plans to support his accomplishment recreation, relationships, or school/day goals.
- Individual #8's ISP did not integrate supports to address her mobility or behavioral risks.
- Individual #435's positioning and other medical supports were not integrated into his supports for participation in the community. The PNMT noted that his medication might impact his PNMT supports. Pharmacy was not involved in developing supports.
- Individual #172's IDT met on 4/19/17 to review seven peer-to-peer aggression incidents. Strategies to minimize her risk of injury from peer-to-peer aggression were not addressed in her ISP.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In particular, medical supports were rarely integrated into support plans developed by other disciplines. Individual #172's IDT did integrate OT/PT and behavioral supports into strategies to address her recreation and relationship goal. In addition to the examples in indicator 12, other examples where disciplines needed to further integrate supports:

- For Individual #51, his PCP, pharmacist, and nurse were not present for input at the PNMT review. The IDT did not consider the possible impact of his neurology medication on his GI risks. Behavioral supports were not integrated into developing PNMT supports to address eating and walking, though behavior was considered to be a barrier to effective implementation of supports.
- Individual #428's team did not consider the need for integrated behavior and PNMT supports, though many of his falls were attributed to behavior.
- Individual #487's communication supports were not integrated into other action plans.
- Individual #8's PCP was not involved in the development of her ISP.

14. Meaningful and substantial community integration was absent from the ISPs.

15. Two of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #428 had a goal to work in the community based on his known preferences. Individual #487 had a goal to increase his school attendance to full day. Action plans to support these goals, however, had not been implemented and barriers to implementation not addressed by the IDT. Overall, vocational/day assessments were not adequate for determining preferences. For example:

- Individual #51's action plans and skill acquisition plans were on hold while he was living in the infirmary following hospitalization. His team failed to develop alternate day programming. The team expressed concerns that his inactivity and

lack of movement could contribute to his GI issues, skin breakdown, and mobility. There was no plan in place to ensure that he was getting up and walking during the day or that he would be involved in any functional training.

- Individual #8's ISP noted that she did not enjoy her job at the workshop and often refused to work. The IDT had not conducted a work assessment that included work exploration to determine what other jobs she might like.
- Individual #435 had a goal to attend work without consideration of his preferences for work.
- Individual #172 had a goal to attend the retirement program. She was not of retirement age and had no work history. Discussion of her day program did not address her preferred activities or consider skill building opportunities.

16. None of the ISPs supported substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs.
Based on observations, individuals were rarely engaged in functional training during the day that might lead to gaining new skills and greater independence. The facility should consider developing a broader range of options for day programming, including but not limited to employment/vocational training. Greater focus should be placed on goals and action plans that support community integration.

Individuals did not have action plans to support sufficient functional skill building opportunities, particularly in relation to developing functional work skills and supporting community integration.

- Individual #428 attended the workshop daily. Observations indicated that he could easily complete the contract work that he had been assigned. He was not engaged in any activities to support skill development or accomplishment of his goal to work in the community.
- Although Individual #487 had a goal to increase his school attendance to full day, his goal had not been implemented and school was out for the summer. His plan did not address functional skill building or engagement during the summer months.
- As noted above, Individual #51's action plans were on hold while he was in the infirmary. His IDT had not developed alternate plans for engagement and supports while recovering from his surgery.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Most notably, barriers to consistent implementation of action plans were not addressed.

18. Three action plans, for Individual #487 (one) and for Individual #172 (two), described detail about data collection and review, however, overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated and, in many cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented.

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, performance was about the same as last time, with some indicators scoring slightly higher and some scoring slightly lower. More focus was needed to ensure that all of the activities occurred related to supporting most integrated setting practices	Individuals:

within the ISP. Primary areas of focus are conducting thorough discussions of living options and putting plans into place to address obstacles to referral. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	51	428	487	8	435	172			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	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.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	50% 3/6	1/1	0/1	1/1	0/1	0/1	1/1			
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	0/1	0/1	0/1	0/1	1/1	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.	0% 0/5	0/1	N/A	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Comments: 19. Five of six ISPs included a description of the individual's preference and how that was determined. The exception was Individual #172. Her ISP noted that her she could not express her preferences, but enjoyed visits to community providers. The ISP, however, did not include preferences in her current environment or note what she liked about visits to community providers.											

21. One of the six ISPs fully included the opinions and recommendation of the IDT's staff members. ISPs for Individual #51, Individual #8, Individual #435, and Individual #172 did not include input from their PCP, though all had significant medical needs. Individual #428's ISP did not include a summary statement regarding the IDT's recommendation.

22. Three of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Individual #8 and Individual #435's ISP did not include input from their LARs. Individual #428's ISP did not include a summary statement

23. One of the individuals (Individual #428) had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #51, Individual #487, Individual #8, Individual #435, and Individual #172's ISPs did not clearly define their living preferences and/or what supports could/could not be provided in the community.

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

26. One of the six individuals (Individual #435) had individualized, measurable action plans to address obstacles to referral or transition, if referred. For the most part, action plans were not measurable, as noted above. Individuals had broad-based general action plans to participate in group home tours.

28. None of the ISPs included specific action plans to educate individuals on living options when relevant. Individual #428 had recently lived in the community and was already familiar with living options.

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

Summary: ISPs were revised annually. This has been the case for some time at Abilene SSLC, therefore, indicator 30 will be moved to the category of requiring less oversight. ISPs, however, were not implemented in a timely manner, and some aspects were not implemented at all. There was improvement in IDT member participation/attendance in the important annual meeting, but criterion was not met. These other indicators (31-34) will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	428	487	8	435	172			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	33% 2/6	0/1	0/1	0/1	1/1	0/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

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

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

- QIDP monthly reviews from September 2016 through February 2017 indicated that Individual #51's relationship goal had not yet been implemented.
- QIDP monthly reviews indicated that Individual #428's relationship goal had not yet been implemented.
- Individual #8's greater independence goal from her 5/17/16 ISP was not implemented from July 2016 through September 2016, then it was discontinued.
- QIDP monthly reviews indicated that Individual #172's recreation and living option goals were never implemented
- There were no data to support implementation of any of Individual #435 or Individual #487's goals.

33. Two of six individuals participated in their ISP meetings. Individual #51, Individual #428, Individual #487, and Individual #435 did not attend their annual ISP meetings.

34. Overall, attendance at annual ISP meetings by IDT members had improved. None of the individuals, however, had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. PCP participation in the IDT process was not evident in any of the ISPs.

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

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Performance remained about the same as last time for both indicators, both below criteria. A full set of assessments is needed for the IDT to thoroughly complete its work. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	428	487	8	435	172			
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.	33% 2/6	0/1	1/1	0/1	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	0/1	1/1	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 two of six individuals.

- Individual #51's IDT did not request comprehensive assessments. He had a significant change of status over the past year.
- Individual #487's IDT did not request a vocational assessment to evaluate the need for job skills training.
- Individual #8's IDT did not request an updated vocational assessment, though she reportedly did not like her current job.
- Individual #172's IDT did not request a vocational assessment. There was no evidence that her vocational interests had been explored.

36. One of the IDTs arranged for and obtained needed, relevant assessments prior to the IDT meeting. Without relevant assessments available to IDTs prior to the annual ISP meeting, it was unlikely that all needed supports and services were included in the ISP. Assessments that were either not submitted or submitted late included:

- For Individual #51, the QIDP assessment summary indicated that his FSA was submitted late and his FSA and OT/PT assessments were updates of his 2016 assessments. The IDT should have completed a comprehensive assessment because he experienced a significant change of status over the past year due to medical events.
- Individual #428's annual medical assessment, behavioral assessment, psychiatric evaluation, and function skills assessment were submitted late according to the QIDP assessment data.
- Individual #8's behavioral assessment was not submitted 10 days prior to her annual ISP meeting for review by the IDT.
- Per QIDP assessment data, Individual #435's medical assessment, behavioral assessment, communication assessment, and nutritional assessment were submitted late.
- Individual #172's medical and behavioral assessments were submitted late.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: Progress was not adequately being reviewed by QIDPs and IDTs. Consequently, actions were not developed or taken. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	428	487	8	435	172			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs met monthly to review supports and progress towards goals. This was good to see, however, there was little evidence that

IDTs also met when a serious incident occurred or a trend of incidents was identified (e.g., multiple falls, emesis, peer to peer aggression). When recommendations were made or supports were revised, IDTs rarely met again to ensure recommendations were implemented. Reliable and valid data were often not available to guide decision-making. As noted throughout this report, little progress was made towards achieving personal goals. Examples included,

- Individual #8 had 16 seizures in April 2017. Her IDT did not meet to discuss her increase in seizures.
- Individual #428's mobility supports were discontinued in March 2017. In April 2017, he had 10 falls and in May 2017, an additional nine falls. The IDT did not meet to discuss implementing new supports to minimize his risk of injury.
- Individual #172 was the aggressor in eight peer to peer incidents between 2/16/17 and 4/4/17. The IDT did not document review of the incidents until 4/19/17. There were no recommendations and no follow-up to that meeting.
- Individual #435's QIDP monthly review for January 2017 noted no pressure ulcers during the review period, however, other documentation indicated he had pressure ulcers on his toe, head, and right heel during January 2017. No other team meetings were documented in January to discuss his pressure ulcers.

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

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

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

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

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

Individuals:

#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	The individual's risk rating is accurate.	33% 6/18	1/2	0/2	0/2	1/2	0/2	0/2	2/2	1/2	1/2
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	56% 10/18	0/2	0/2	1/2	2/2	1/2	1/2	2/2	1/2	2/2

	change of status occurs.										

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #51 – skin integrity, and constipation/bowel obstruction; Individual #428 – gastrointestinal (GI) problems, and falls; Individual #172 – falls, and urinary tract infections (UTIs); Individual #551 – weight, and constipation/bowel obstruction; Individual #264 – weight, and falls; Individual #541 – constipation/bowel obstruction, and UTIs; Individual #7 – cardiac disease, and fractures; Individual #435 – weight, and choking; and Individual #212 – skin integrity, and fractures].

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 #51 – constipation/bowel obstruction; Individual #551 – weight; Individual #7 – cardiac disease, and fractures; Individual #435 – choking; and Individual #212 – fractures.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The individuals that score positively for this indicator did not have changes of status in the specified risk areas.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: This outcome requires individualized diagnosis-specific personal goals be created for each individual and that these goals reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. It was encouraging to see some progress along these lines. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4. All of the individuals had identified target behaviors that were related to their psychiatric disorder. The primary identified target

behavior for everyone, except Individual #557 and Individual #8, was physical aggression. The primary identified behavior for Individual #557 was copraphagia and for Individual #8 it was verbal hostility. Individual #8 also had a psychiatric indicator that was a depression rating. There were references to at least one pro-social behavior that could be translated into positive goals for all of the individuals, however, these were not developed into functional measurable goals. The target behaviors were all part of individuals' PBSPs.

5. Neither the positive nor the negative behaviors were defined in a manner that could easily be formulated into measurable goals.

6. The facility performed periodic thorough assessments in the form of the PTPs as well as the annual updates to the CPEs. The negative target behaviors were based on these assessments, but as described above the target behaviors themselves alone did not constitute measurable goals.

7. The behavioral data that were generated at Abilene SSLC were not found to be reliable.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: All individuals had a CPE. This was now the case for all individuals, with one exception, for this review and the past two reviews. Therefore, this indicator (12) will be moved to the category of requiring less oversight. On the other hand, the content of the CPEs did not meet criteria for a number of individuals. Content is indicator 14, which was moved to the category of requiring less oversight after the last review. To maintain this categorization, CPE content needs to meet criteria. Performance on indicators 15 and 16 was about the same as the last review. Both of these indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 487	557	530	482	293	428	8	444	51
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
14	CPE content is comprehensive.										
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.	75% 3/4	1/1	1/1	N/A	1/1	N/A	0/1	N/A	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.	33% 3/9	1/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1

Comments:
12. All of the individuals had a completed CPE.

14. A number of the CPEs were incomplete, missing physical exam, lab values, symptoms of diagnosis, and a thorough formulation. Without improvement, at the next review this indicator might be moved back into active monitoring.

15. Individual #487, Individual #557, Individual #482, and Individual #428 were admitted to the facility since 1/1/14. For each of these individuals, there was evidence of an integrated progress note prepared by a member of the medical department on the day of admission. All of these, except Individual #428, had a CPE completed by a member of the psychiatric department with 30 days of admission.

16. The psychiatric diagnoses were consistent throughout the medical record for three individuals. The psychiatric diagnoses in the records of Individual #530, Individual #482, and Individual #444 were consistent in the psychiatric and behavioral health sections of the record, but the diagnoses in the annual medical assessment were different. For Individual #8 and Individual #51, the diagnoses in the behavioral and medical sections were consistent, but differed from those in the psychiatric section. The psychiatric diagnoses for Individual #557 differed in all three of these sections of the record. This could in part be due to his recent admission to the facility and the number of psychiatric diagnoses he had received while living in the community.

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

Summary: The annual update documentation was complete with one important exception regarding the interaction between an anti-psychotic medication and an active seizure disorder. Performance on indicators 20 and 21 did not maintain and, therefore, these two indicators, as well as indicator 18, will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 487	557	530	482	293	428	8	444	51
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	44% 4/9	1/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1

Comments:

18. The annual clinical update with information for the ISP primarily appeared in the psychiatric treatment plan (PTP), which is prepared in sequence with the ISP. These documents contained the required information for everyone except Individual #293. The deficiency related to the lack of a discussion of the risk of clozapine related to his active seizure disorder. The side effect of clozapine producing seizures is listed as a potential side effect, but there was no discussion of the fact that the AMA noted that he had three documented seizures in the past year prior to the ISP. Thus, a discussion of whether the frequency of seizures had increased, decreased, or stayed the same with the introduction of the clozapine would have been expected.

20. A licensed member of the psychiatric team attended the ISP meeting for all of the individuals, except Individual #530, Individual #293, and Individual #51. The available documentation during the onsite review indicated that the IDT Team had determined during the ISP preparation meeting that the psychiatric provider did not need to attend the ISP for Individual #530, Individual #293 and Individual #51. This decision appears to have been warranted for Individual #530 because he was relatively stable, however, this was not the case for the other two individuals.

21. The documentation in the ISPs was found to contain the essential elements for four of the individuals, that is, not for Individual #530, Individual #482, Individual #428, Individual #293, and Individual #51. The deficits in these five involved the lack of the justification for the conclusion that the interventions were the least intrusive, as well as the integration of behavioral and pharmacological treatments. As noted above for Individual #293, the risk versus benefit discussion also did not include a discussion of any correlation between his active seizure disorder and the clozapine.

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

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: Indicators 28 and 29 will be moved to the category of requiring less oversight given the high performance scores on this review and the last review and improvement from Round 10 review. Indicators 31 and 32 with sustained high performance might be moved to this category too after the next review. Indicators 30, 31, and 32 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
28	There was a signed consent form for each psychiatric medication, and	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	each was dated within prior 12 months.	9/9									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	7/9 78%	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	9/9 100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
28-29. Criteria were met for all of the individuals. There were other positive aspects about this, such as, in addition to the drug profiles, the staff sent the admission CPE (Individual #557), or the PTP (Individual #8).

30. There was an adequate risk benefit discussion in the consent for each of the individuals, except Individual #482 and Individual #293.

- The discussion for Individual #482 did not contain a discussion of the risk related to the need for restraint in order to administer the IM Risperdal Consta on those occasions when she was not fully cooperative. The behavioral health team tracked the frequency of restraint related to these administrations and there was a plan to reduce them. The psychiatric team indicated that this issue was discussed with her guardian who had provided verbal consent, but this procedure was not included in the written consent documentation.
- The discussion for Individual #293 did not include a detailed discussion of the possible impact of the clozapine on his active seizure disorder. The potential for seizures was listed as a potential side effect, but there was no discussion of the reference in the most recent AMA to three documented seizures in the past year and whether the frequency of seizures had increased, decreased, or stayed the same since the introduction of the clozapine.

31. The references to alternate non-pharmacological interventions contained in the consents for each individual were specific to the individual and referenced a number of different potential interventions.

32. HRC approvals met criteria for the medications. HRC approval for the medical restraint for medication administration for Individual #482 was also available. Psychiatric documentation, however, did not refer to the use of medical restraint. Restraint was used only when needed, which was three times in the 10-month period July 2016 through April 2017.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Indicator 4 showed steady improvement across three consecutive reviews. With sustained high performance, it might be moved to the category of requiring less oversight. Ensuring that data are reliable (and thereby, useful) is a priority area for the facility and the behavioral health services department. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. Although this indicator was moved to the category of requiring less oversight, after speaking with staff and conducting observations, the behavioral health department should consider completing a functional behavior assessment and corresponding PBSP for Individual #264 who engaged in aggression and inappropriate verbal behavior (e.g., swearing, racial slurs).

4. Goals/objectives, and counseling plans, too, had measurable objectives that were based upon their assessments.

5. The Monitoring Team determined that the data system in place for the six-month period prior to the onsite visit did not provide reliable data. Data timeliness was assessed over eight-hour blocks of time. Additionally, several plans noted a change in data collection during this same period of time with questions noted regarding data accuracy (e.g., Individual #428's progress report noted an increase in certain target behaviors "…primarily due to change in data collection;" Individual #482's graphs were labeled interval, but noted a change in data collection in January 2017; Individual #293's progress note indicated a change to frequency measure [no date identified] suggesting a new baseline will be established).

Outcome 3 - All individuals have current and complete behavioral and functional assessments.												
Summary: The facility continued to struggle with moving forward on these indicators. Assessment plays an important role in the provision of behavioral health services, and although the functional assessments were current and complete for most individuals, improvements in performance are necessary for these indicators to move to the category of requiring less oversight. They will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
10	The individual has a current, and complete annual behavioral health update.	33% 3/9	0/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
12	The functional assessment is complete.	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:

10. At the time of the onsite visit, seven of nine individuals had current behavioral health assessments. The exceptions were Individual #8 and Individual #51. However, only the assessments for Individual #530, Individual #482, and Individual #428 were rated as complete. The assessments for Individual #487, Individual #557, Individual #293, and Individual #444 were missing information regarding the individual's physical health over the previous 12 months

11. The functional assessment was current for seven of the nine individuals. The exceptions were Individual #8 and Individual #51.

12. Seven of the functional assessments were considered complete (Individual #487, Individual #530, Individual #482, Individual #428, Individual #8, Individual #444, Individual #51). Each contained indirect and descriptive assessments completed within the past 12 months. It is advisable to repeat these assessments annually, or when new, unwanted behaviors emerge or when targeted problem behaviors are worsening. Assessments would be enhanced with more frequent observations of problem behaviors to ensure a better understanding of antecedents and consequences. Individual #557's assessment lacked a clear summary statement and Individual #293's assessment did not include updated indirect assessments.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: There was no longer any use of exclusionary timeout and use of the respite home had decreased and was under much improved guidelines for implementation and monitoring. PBSP content continued to improve. Aspects of the PBSP content that requires focus are listed below. These two indicators, 13 and 15, will remain in active monitoring.			Individuals:								
#	Indicator	Overall	487	557	530	482	293	428	8	444	51

		Score									
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	67% 6/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1	0/1
14	The PBSP was current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	The PBSP was complete, meeting all requirements for content and quality.	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 the nine PBSPs were implemented within 14 days of required consents. The exceptions were Individual #530, Individual #293, and Individual #51.

14. For eight of the nine individuals, the PBSP was current (i.e., implemented within the last 12 months). The exception was Individual #428 whose plan was dated 4/21/16. It should be noted that a new plan was reviewed at the meeting of the Behavior Support Committee on 4/26/17, with consent and implementation taking place on 5/18/17.

15. Although none of the PBSPs were complete, many of the sub-indicators were met in the majority of the plans. This included the following: operational definitions of targeted problem behaviors, operational definitions of replacement behaviors (exceptions were Individual #557, Individual #8, and Individual #444), antecedent strategies, consequent strategies (exception was Individual #444), description of training of replacement behaviors, functional replacement behaviors (exceptions were Individual #8 and Individual #444), and clear, precise interventions (exception was Individual #444).

Areas for improvement in PBSP content included:

- Missing from most plans was the use of positive reinforcement in a manner that was likely to be effective. Although the plans for Individual #487 and Individual #557 noted the use of a token system in the form of punch cards, there was no clear description of the exchange policy.
- None of the plans provided sufficient scheduled opportunities for the development/strengthening of replacement behaviors.
- Only the plans for Individual #444 and Individual #51 included baseline or comparison data.
- Many of the plans indicated that staff were to document as prompted in the electronic record. This did not provide a clear indication of the measurement system that was in place to track targeted behaviors.

Individual-specific concerns included:

- The plan for Individual #482 that noted that if a meal was provided during a behavioral crisis, it could be replaced with a sack lunch. Meals should not be altered as a result of problem behaviors. As discussed with the director of behavioral services, staff should also make every effort to ensure the replacement behavior is less effortful than the identified problem behaviors.
- In the updated PBSP for Individual #428 (provided during the onsite visit), he was to use multiple word utterances to express his wants/needs. As noted in his ISP, this is an individual who typically spoke in one to two word utterances. Therefore, the replacement behavior is likely to be difficult for him to perform, making it likely that problem behavior would be more functional and effective for him.

Following the last onsite visit, the Monitoring Team made several recommendations regarding the use of a respite home. Between 10/1/17 and 3/31/17, two individuals had accessed the respite home for between one and two nights. Each placement resulted in only one night away from the individual's assigned home. The respite home policy had been developed on 2/28/17 and revised on 3/28/17, and included the following positive guidelines:

- completion of the IDT Consideration of Need for Respite Services to include consideration of relevant psychosocial and environmental factors;
- consultation with the Director of Behavioral Health Services to consider alternatives to respite;
- unless otherwise approved, a home direct support professional and a behavior coach will be assigned to work with the individual;
- the assigned behavior analyst or on call behavior analyst/behavioral health specialist must visit the respite home at least once per shift during regular work hours, and at least once between 6:00 am and 2:00 pm and 2:00 pm to 10:00 pm on weekends;
- the director of behavioral health services or his/her designee will visit the respite home daily during regular work hours;
- active treatment should continue unless the IDT determines otherwise;
- the behavior analyst will assure treatment integrity, data timeliness, and data reliability measures for any respite service lasting longer than 24 hours;
- respite services lasting longer than three days will result in a review and possible revision of the individual's daily schedule/current PBSP/CIP, initiation of an updated functional assessment, and review of the individual at the next meeting of the internal peer review committee; and
- the use of respite services will be reviewed at the meeting of the Restraint Reduction Committee.

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

Summary: Criteria were met for indicator 25 for this review and the two previous reviews, too. Therefore, indicator 25 will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 487	557	530	482	293	428	8	444	51
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A

Comments:
25. Individual #482 had a complete counseling treatment plan and corresponding progress notes. Individual #557 had begun counseling approximately two months prior to the onsite visit and, as described in the notes provided, the counselor was still establishing rapport and had not yet developed a treatment plan.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: It was concerning that most individuals reviewed had not received timely annual medical assessments. Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	33% 3/9	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. It was concerning that most individuals reviewed had not received timely annual medical assessments. c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.										

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	Individual receives quality AMA.	56% 5/9	1/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	individualized needs, but no less than every six months.	0/18									

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

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #51 – constipation/bowel obstruction, and weight; Individual #428 – seizures, and weight; Individual #172 – cardiac disease, and falls; Individual #551 – weight, and seizures; Individual #264 – cardiac disease, and weight; Individual #541 – gastrointestinal (GI) problems, and cardiac disease; Individual #7 – respiratory compromise, and GI problems; Individual #435 – osteoporosis, and urinary tract infections (UTIs); and Individual #212 – aspiration, and GI problems].

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

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
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.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. Medical interventions generally were not included in individuals' IHCPs. The exception was the IHCP for osteoporosis for Individual #435.

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

Dental

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

Summary: Given that over the last two review periods and during this review, the Dental Department completed the dental summaries reviewed timely (Round 10 – 100%, Round 11 – 100%, and Round 12 – 100%), Indicator a.iii will move to the category requiring less oversight. Over this review and the last one, improvement was noted with regard to the timely completion of annual dental exams. If the Center sustains this progress, Indicator a.ii might move to the category requiring less oversight after the next review. The Center should continue its focus on improving the quality of dental exams and summaries.

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 7/7	1/1	1/1	N/R	1/1	1/1	N/R	1/1	1/1	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	N/R	1/1	1/1	N/R	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	22% 2/9	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	29% 2/7	0/1	0/1	N/R	0/1	0/1	N/R	0/1	1/1	1/1

Comments: a. Individual #172 and Individual #541 were edentulous, and were part of the outcome group, so a limited review was conducted. It was positive that the Dental Department completed timely dental exams and summaries for the remaining individuals.

b. It was positive that for Individual #172 and Individual #541, the dental exams included all of the required components. It was also good to see that all of the remaining dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral cancer screening;
- Sedation use;
- An oral hygiene rating completed prior to treatment;
- A description of periodontal condition;
- An odontogram;

- A summary of the number of teeth present/missing;
- Caries risk;
- Periodontal risk;
- Specific treatment provided;
- The recall frequency; and
- A treatment plan.

Most, but not all included:

- Periodontal charting.

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

- Information regarding last x-ray(s) and type of x-ray, including the date.

c. It was positive that for Individual #435 and Individual #212, the dental summaries included all of the required components. It was also good to see that all of the remaining dental summaries included the following:

- Recommendations related to the need for desensitization or another plan;
- A summary of the number of teeth present/missing;
- Provision of written oral hygiene instructions;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations;
- A description of the treatment provided; and
- Treatment plan, including the recall frequency.

Most included:

- Effectiveness of pre-treatment sedation.

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

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

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.	
Summary: Due to previous high performance with regard to the completion of new admission and annual nursing reviews and physical assessments, Indicators a.i and a.ii moved to the category requiring less oversight. However, based on the annual nursing assessments the Monitoring Team used for other elements of its review, problems were noted with regard to the completion of complete physical assessments, including weight graphs, fall assessments, assessments of reproductive systems, and, in some cases, Braden scores. As a result, Indicators a.i and a.ii will move back to active monitoring. The remaining indicators require	Individuals:

continued focus to ensure nurses complete timely quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.											
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight. However, due to regression in the completion of complete physical assessments, these indicators will move back to active monitoring.									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.										
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	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 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.	38% 3/8	1/2	1/1	0/1	0/2	N/A	0/1	N/A	1/1	N/A

Comments: a. Based on the Monitoring Team's use of annual nursing assessments and physicals for other elements of its review, problems were noted for eight of the nine individuals (i.e., the exception was Individual #7) with regard to completion of complete physical assessments, including weight graphs, fall assessments, assessments of reproductive systems, and, in some cases, Braden scores. As a result, Indicators a.i and a.ii will move back to active monitoring. Similarly, quarterly physicals were missing these critical components.

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

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #51 – skin integrity, and constipation/bowel obstruction; Individual #428 – GI problems, and falls; Individual #172 – falls, and UTIs; Individual #551 – weight, and constipation/bowel obstruction; Individual #264 – weight, and falls; Individual #541 – constipation/bowel obstruction, and UTIs; Individual #7 – cardiac disease, and fractures; Individual #435 – weight, and choking; and Individual #212 – skin integrity, and fractures).

The nursing assessment that sufficiently addressed the risk area was for fractures for Individual #212. However, 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.

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 four 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: 51	428	172	551	264	541	7	435	212
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
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).	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2
d.	The IHCP action steps support the goal/objective.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2

Comments: a. through f. The IHCPs that included some of the necessary components were those for weight for Individual #435, and skin integrity for Individual #212.

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: It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. This was an improvement from the last review when the Center's score was 17%. In addition, since the last review, the scores during this review showed improvement with regard to timely referral of individuals to the PNMT, and timely review. The Center should focus on sustaining or continuing its progress in these areas, as well as improving completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments.			Individuals:							
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	71% 5/7	1/1	1/2	N/A	N/A	N/A	0/1	1/1	1/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	71% 5/7	1/1	1/2				0/1	1/1	1/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4	0/1	N/A				N/A	0/1	0/1	0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	29% 2/7	0/1	1/2				0/1	0/1	1/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 6/6	1/1	2/2				N/A	1/1	1/1	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/7	0/1	0/2				0/1	0/1	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status;	0% 0/3	0/1	0/1				0/1	N/A	N/A	N/A

	• 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% 0/4	0/1	N/A				N/A	0/1	0/1	0/1

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

- The PNMT reviewed Individual #51 timely with regard to GI problems, and weight. However, due to the severity of the ongoing issues and the impact his decreased intake as well as the GI issues had on his health, a comprehensive assessment was warranted that focused on meals, Head-of-Bed assessment, reconditioning, behavior, malnutrition, etc. The PNMT did not conduct a comprehensive assessment. Based on the limited review conducted, the PNMT did not clearly determine why Individual #51 was on a liquid diet. Although their input was needed, no PCP, Pharmacist, or Behavioral Health Services staff (i.e., he tended to become aggressive during mealtimes) participated in the PNMT review.
- The PNMT conducted a timely review of Individual #428's fracture. However, he experienced an increase in falls, yet the PNMT did not review these falls in a comprehensive manner to determine the underlying cause of the increase. In addition, because it appeared some of the falls potentially had a behavioral component, Behavioral Health Services staff should have participated in the PNMT review, but did not.

  In December 2016, when Individual #428 was diagnosed with pneumonitis, the PNMT did not conduct a review, and indicated the reason was he did not have pneumonia. However, pneumonitis can be caused by pneumonia, GERD, reflux, etc. Therefore, at least a PNMT review was warranted.
- The PNMT did not conduct a review of Individual #541's long bone fracture that occurred on 8/30/16. Due to the individual's complex medical issues and the potential impact of the fracture on multiple facets of care, a PNMT review was warranted.
- For Individual #7, the PNMT conducted reviews in response to increased secretions (5/15/16), respiratory illness – shortness of breath (6/10/16), and pneumonia (9/12/16). Due to the compounding and potentially related issues, a comprehensive assessment was warranted, but the PNMT did not complete one.
- For Individual #435, on 1/27/17, the PNMT initiated an assessment, but did not complete it until 3/9/17, with no clear explanation provided as to why the assessment took longer than 30 days. The assessment noted that some of the medications prescribed to Individual #435 could be causing the vomiting, but offered no further explanation or investigation as part of the PNMT assessment. No PCP or Pharmacist participated in the review/assessment.
- Individual #212 had a significant history of respiratory compromise, due in part to multiple aspiration pneumonia diagnoses over the past two years. The PNMT conducted a review, but the review did not identify or analyze potential underlying causes of the aspiration pneumonia, or provide recommendations to address relevant areas. No medical provider participated in the review. The respiratory issues had become such an issue that Center staff used them to justify the DNR Order status. Given this, an assessment was warranted to ensure additional interventions would not have improved her condition. This is further discussed in the medical section of this report (i.e., Outcomes #5 and #8). While the PNMT had completed an assessment in January 2015, it was almost two years old.

e. It was positive that an RN Post Hospitalization Review was completed as applicable for the individuals reviewed, and the PNMT discussed the results.

h. As noted above, three individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #51, Individual #7, and Individual #212). The following summarizes some of the concerns noted with the one assessment that the PNMT completed:

- Many of the components of Individual #435's PNMT assessment did not meet criteria. As a couple of examples, the assessment lacked adequate investigation and analysis to identify the underlying cause(s) for the issues. The assessment stated that medications could be causing the vomiting, but offered no further information. It also noted that his scoliosis with left convexity had progressed and gotten worse, but again offered no clear intervention.

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

Summary: No improvement and some regression was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	33% 3/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	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.	11% 2/18	0/2	0/2	0/2	2/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	9% 1/11	N/A	0/1	0/2	1/1	0/1	0/1	0/2	0/1	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: GI problems, and weight for Individual #51; aspiration, and fractures for Individual #428; choking, and aspiration for Individual #172; choking, and skin integrity for Individual #551; choking, and falls for Individual #264; aspiration, and fractures for Individual #541; choking, and aspiration for Individual #7; weight, and aspiration

for Individual #435; and aspiration, and choking for Individual #212.

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

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs for Individual #7, Individual #435, and Individual #212 included all of the necessary components to meet the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example, problems were noted with regard to risks and triggers for five individuals (e.g., risks did not match across documents, necessary triggers were not included or did not match across documents, risk levels were not included); Individual #172's PNMP did not include a picture that showed her correctly positioned in bed; and Individual #51's PNMP included conflicting information about which spoon to use.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for choking, and skin integrity for Individual #551.

f. The IHCP that identified triggers and actions to take should they occur was for choking for Individual #551.

g. For the risk areas of the individuals reviewed, the IHCPs did not include the frequency of PNMP monitoring.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
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.	75% 3/4	N/A	N/A	N/A	N/A	N/A	0/1	1/1	1/1	1/1
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	50% 1/2						0/1	1/1	N/A	N/A
Comments: a. and b. While an assessment was conducted to determine the feasibility of Individual #541 returning to oral intake, a plan was lacking that would assist her down the path to where enteral nutrition was not required.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has been consistently been low. The quality of OT/PT assessments also continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	56% 5/8	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	33% 3/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports;	N/A									

	• Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	0/1	N/A	N/A	N/A	N/A	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/4	N/A	0/1	0/1	0/1	0/1	N/A	N/A	N/A	N/A

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

- Due to the significant changes that Individual #51 experienced over the past year, a comprehensive assessment was warranted, but the OT/PT only completed an update. In addition, the OT/PT did not complete an assessment in response to his constant rocking in his chair, which increased friction and risk of skin breakdown. The Center did not provide evidence of a seating assessment or development of a custom mold for his chair that would provide better support and potentially mitigate risk.
- Since 2/1/17, Individual #428 fell approximately 20 times, but the PT had not completed a full gait and balance assessment.
- On 6/27/16, the OT/PT submitted Individual #551's update for the ISP meeting that occurred on 6/29/16.
- Individual #264 had an increase in falls and decrease in balance, yet no consult was provided in response to this change in status.
- Individual #541's update stated that the IDT requested a comprehensive assessment, but one was not provided. The OT/PT offered no justification within the update for not providing a comprehensive assessment. The last comprehensive assessment was completed in 2012.
- The last comprehensive OT/PT assessments found for Individual #7 (2013), Individual #435 (2012), and Individual #212 (2013) were three to four years old. Given the needs and physical changes of these individuals, information was not found to justify the length of time between comprehensive assessments.

d. As noted above, five individuals who should have had comprehensive assessments did not (i.e., Individual #51, Individual #541, Individual #7, Individual #435, and Individual #212).

e. The following summaries some of the concerns noted with regard to the required components of the OT/PT updates reviewed:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: None of the updates identified whether or not the individual experienced potential side effects, and/or provided an analysis of the possible impact on OT/PT 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: One update did not provide a functional description of the individual's skills;
- 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): For one individual, the review did not reflect an actual

observation of the individual in the wheelchair, or provide data to support the conclusion that the wheelchair met the individual's needs;

- 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: For three individuals, the updates only stated that the individual experienced a functional decline, but did not provide details or functional analysis of the decline;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: All of the updates reviewed had concerns noted with this sub-indicator. Often, the updates provided no review of monitoring findings, and/or stated effectiveness was "good" without any data to support this conclusion;
- 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: Because individuals often did not have goals/objectives that were clinically relevant and measurable, the updates often did not include evidence regarding progress, maintenance, or regression. In addition, even when individuals had OT/PT needs that were not met or had changes in status possibly necessitating additional services, updates did not fully address these needs; 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: Some updates did not address identified needs through recommendations, provide the necessary detail to allow IDTs to develop meaningful programs, and/or recommend integration of OT/PT supports into other programs.

On a positive note, as applicable, all of the updates reviewed provided:

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

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: It was good to see improvement from the last review with regard to IDTs reviewing and making changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually, as well as including a functional description of the individual from an OT/PT perspective in the ISPs. As noted above, assessments did not identify all of the necessary strategies, interventions, and programs necessary to meet individuals' OT/PT needs. However, IDTs often included those strategies that were identified in individuals' ISPs/IHCPs, which was also positive. The Monitoring Team will continue to review these indicators.

Individuals:

#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	The individual's ISP includes a description of how the individual	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	functions from an OT/PT perspective.	9/9									
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	92% 11/12	1/1	2/2	1/1	2/2	2/2	1/1	0/1	1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	71% 5/7	0/1	1/2	N/A	1/1	2/2	1/1	N/A	N/A	N/A

Comments: c. and d. As noted above, assessments did not identify all of the necessary strategies, interventions, and programs necessary to meet individuals' OT/PT needs. However, IDTs often included those that were identified in individuals' ISPs/IHCPs. The exceptions were:

- More specifically, in the April 2016 assessment, the OT/PT stated that working with Individual #7 on sustaining eye contact would help with head/neck strength. There was no evidence that this program was integrated into existing programs or developed as a stand-alone program.
- Individual #51's IDT did not meet to discuss the use of the gait belt, and changing the ambulation supports in the PNMP.
- On 2/14/17, the OT/PT recommended a change diet texture for Individual #428, but stated the OT/PT would share it with the team at the monthly meeting. Issues of this magnitude should trigger a meeting as soon as possible, and should not wait until the monthly scheduled meeting.

Communication

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

Summary: It was good to see improvement with regard to the timeliness of communication assessments, as well as the completion of the correct type of assessment (i.e., an update versus a comprehensive communication assessment). However, significant work was needed to improve the quality of the communication assessments. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual	N/A									

	receives a timely communication screening or comprehensive assessment.										
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ 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.	N/A									
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. Individual #435's Communication Update was completed/submitted on the same day as his ISP meeting. e. The following provide examples of concerns noted with regard to the required components of the communication updates for the individuals reviewed: • The individual's preferences and strengths are used in the development of communication supports and services: Most of the updates failed to utilize the individuals' communication strengths to further develop communication skills and abilities; • Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and											

services: None of the updates met this criterion. Although medications and potential side effects were listed, the updates did not provide information about whether or not the individual experienced such side effects and/or whether or not they were potentially impacting communication;

- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: Five of the updates merely stated that the individual's communication remained unchanged without providing details in the relevant sections of the assessment (e.g., receptive, expressive);
- Analysis of the effectiveness of current supports, including monitoring findings: None of the updates reviewed monitoring findings;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: Five of the updates did not meet this criterion. Overall, the assessments of communication needs were not sufficiently broad or timely. For example, some relied on previous assessments and dated information to draw the conclusion that AAC or language-based therapy would not benefit the individual, others relied on one trial of an AAC device, and as stated earlier, many assessments did not expand upon the individual's existing strengths and abilities to identify AAC devices or communication systems that might work for the individual; 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: A number of the updates did not contain sufficient assessment information to determine whether or not recommendations were needed, many did not offer recommendations to expand the individuals' existing skills, and many did not integrate interventions in goals/objectives for the IDTs' consideration.

On a positive note, all of the updates sufficiently addressed the following:

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

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: During the last review and this one, the ISPs of the individuals reviewed included good descriptions of how the individuals communicate, and how staff should communicate with the individuals. If the Center maintains this improvement, at the time of the next review, Indicator a might move to the category requiring less oversight. At this time, these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual,	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	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.										
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
Comments: c. ISPs included a general set of interventions regarding communication that were found in assessments. However, as noted above, assessments often did not identify a full set of communication strategies, interventions, and programs to meet the individuals' needs. As assessments improve, ISPs also will need to include the hopefully improved recommendations. d. The IDT met to discuss changes to Individual #551's adaptive switch.											

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 continued to have SAPs that were measurable. Performance on indicators 3, 4, and 5 deteriorated slightly from similarly low scores at the last review. Their basis in assessment, practicality, functionality, and meaningfulness remained about the same as did the absence of reliable data. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.	46% 12/26	3/3	2/3	3/3	0/3	0/3	1/3	0/3	2/3	1/2
4	SAPs are practical, functional, and meaningful.	35% 9/26	2/3	2/3	3/3	0/3	0/3	1/3	0/3	0/3	1/2
5	Reliable and valid data are available that report/summarize the	0%	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/2

	individual's status and progress.	0/26									

Comments:
3. While usually three SAPs are reviewed by the Monitoring Team for each individual, Individual #51 had two SAPs, for a total of 26. Twelve SAPs were based upon assessments. For the remaining SAPs, a majority addressed skills that the functional skills assessment indicated the individual could already perform (e.g., Individual #482's hygiene skills and walking program, Individual #293 asking questions and removing his hat, Individual #428 identifying coins, Individual #444 brushing his teeth, and Individual #51 indicating a choice).

4. Nine of the 26 SAPs were considered to be practical, functional, or meaningful. Several SAPs did not teach new skills, rather they addressed compliance issues (e.g., Individual #482's hygiene, Individual #293 removing his hat, and Individual #444's toothbrushing and attending work). Individual #8 was to learn to use her right arm to complete her job to increase her range of motion. As she can independently complete her job using her left arm, it would be more meaningful for therapy to be provided to develop her range of motion. Similarly, Individual #293 was to bring a cup with him to receive his medications, but it would be more meaningful for him to get a cup to pour himself a preferred drink. Further, the nursing assessment had recommended discontinuing this SAP due to ambulation difficulties.

5. The reliability of data was considered inadequate for all the SAPs. As noted below, although integrity measures were assessed and achieved for 12 SAPs, only integrity scores were provided. The accuracy of data recordings could not be assessed.

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: All three indicators had slightly improved scores compared with the last review. Even so, these assessments and content play an important role in the development of individualized treatment programs. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
10	The individual has a current FSA, PSI, and vocational assessment.	56% 5/9	0/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	67% 6/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:
10. Five of the nine individuals had current functional skills assessments, preferences and strengths inventories, and vocational or, where appropriate, day program assessments. The exceptions were Individual #487 and Individual #557 who did not have vocational assessments. Although they were currently enrolled in school, they were 14 years or older and, therefore, initial steps in transition

planning were appropriate. It is advised that a vocational assessment be completed with consideration given to the introduction of work activities particularly as they are out of school for the summer. The functional skills assessments for Individual #530 and Individual #8 were identified as updated, but there was little evidence of changes made to the assessment. In Individual #530's assessment, there were two comments with a more recent date, but both provided the same information as the initial assessment. In Individual #8's assessment, several pages were dated 2014.

11. The assessments that were completed were available to the IDT as least 10 days prior to the ISP for six of the nine individuals.

12. The completed assessments included SAP recommendations for eight of the nine individuals. The exception was Individual #293 whose day program assessment did not include any recommendations for programming. As the FSA is a comprehensive assessment across multiple domains, staff are advised to consider a range of recommendations to help the IDT best identify appropriate goals for the year.

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 implementation of plans by the various clinical disciplines. At the time of the last review, 23 of these indicators, including three entire outcomes, in restraints, psychiatry, behavioral health, medical, pharmacy, dental, and OT/PT, had sustained high performance scores and moved to the category requiring less oversight. Presently, six additional indicators will move to the category requiring less oversight. These were in the areas of restraints, psychology, medical, and dental. One indicator in restraints will move back to active monitoring.

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

Goals/Objectives and Review of Progress

Regarding more than three restraints in any rolling 30-day period, the required content of reviews was not occurring and was less than at the last review.

The psychiatry quarterly documentation contained the required content. In psychiatry clinics, all of the required elements were observed, except for the presentation of the behavioral data and graphs.

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

Acute Illnesses/Occurrences

Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed significant improvement.

It was positive that for many of the acute illnesses reviewed, PCPs and providers conducted assessments and follow-up according to accepted clinical practice. It was concerning, though, that IDTs had not met to conduct post-hospitalization reviews. It is important for IDTs to develop, as appropriate, action steps to address follow-up medical and healthcare supports to reduce risks and promote early recognition.

In psychiatry, without measurable goals, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. There was good improvement in the implementation, review, and documentation of monitoring for side effects of psychotropic medications.

Implementation of Plans

In behavioral health services, staff training was not occurring as much as it was at the time of the last review. Also, proper, useable graphs remained an area of need. The data collection systems were not adequate in measuring either target or replacement behaviors.

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. Work is needed to ensure that PCPs address individuals' chronic or at-risk conditions by completing medical assessments, tests, and evaluations consistent with current standards of care, and identifying the necessary treatment(s), interventions, and strategies, as appropriate. Once identified, these treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

It was positive that over the last two review periods and during this review, for the non-Facility consultations reviewed, the PCPs generally reviewed consultations and indicated agreement or disagreement. As a result, the related indicator will move to the category requiring less oversight. However, work was needed to ensure this occurred in a timely manner. During this review, the Center showed progress with regard to providers ordering agreed-upon recommendations.

Given the inconsistencies the Monitoring Team has consistently found with the Center's compliance with State Office policy, the Center should review the justifications for all individuals with DNR Orders that the Center would execute.

It was positive that for the individuals reviewed, the Dental Department provided prophylactic care, tooth-brushing instruction, and x-rays in a timely manner. Due to the Center's sustained performance with regard to dental x-rays, the related indicator will move to the category requiring less oversight. Work is needed to ensure individuals who need it receive fluoride treatment, and treatment for periodontal disease. In addition, when dental emergencies occur, better nursing and/or dental documentation is needed with regard to the onset of symptoms.

Since the last review, it was good to see improvement with regard to the quality of the Quarterly Drug Regimen Reviews (QDRRs). In addition, when prescribers agreed to recommendations for the individuals reviewed, documentation generally was presented to show they implemented them.

Based on the Monitoring Team's observations, with a few exceptions, individuals' adaptive equipment appeared to fit them properly.

Based on observations, there were still numerous instances (69% of 48 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
Summary: Performance on these important protections for individuals slipped since the last review. Many indicators regarding the required analysis of the restraint episode fell from 100% scores. Indicator 19, regarding the IDT getting together about the restraint and plan, was not occurring and, therefore, this indicator will be moved back to active monitoring. On the other hand, indicators related to the PBSP scored high, such that indicator 24 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	487	482	428						
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.	33% 1/3	0/1	0/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. However, due to poor performance, it will be moved back to active monitoring.									
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and	67% 2/3	0/1	1/1	1/1						

	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.										
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.	33% 1/3	0/1	1/1	0/1						
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/3	0/1	0/1	0/1						
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	67% 2/3	1/1	1/1	0/1						
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 3/3	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).	33% 1/3	0/1	1/1	0/1						
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	100% 2/2	1/1	1/1	N/A						
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 3/3	1/1	1/1	1/1						
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
18-19. Three individuals, Individual #487, Individual #482, and Individual #428, experienced crisis intervention restraint more than three times in a rolling 30-day period. There was evidence that Individual #428's IDT met within 10 business days of the fourth restraint. The facility also provided an Analysis of Restraint form for Individual #428, but this was not dated.

For Individual #487 and Individual #482, the facility reported that there were no ISPAs between October 2016 and March 2017. The

facility did provide an Analysis of Restraint for Individual #487 that was completed by the BCBA and home manager within the required time frame. Similarly, Office Clinic Notes, completed by the BCBA, were provided for Individual #482. Both of these documents provided a review of critical indicators.

The ISPA for Individual #428, the Analysis of Restraint for Individual #487, and the Office Clinic Notes for Individual #482 were used to respond to indicators 20-23 and 29.

20. For all three individuals, there was a discussion regarding the potential role of adaptive skills, and biological, medical, and psychosocial issues. For Individual #482, behavior coaches were to work on the 2-10 shift to provide supervision and training to new staff. For Individual #428, changes were to be implemented in his medication. Although Individual #487 was noted to have difficulty waiting, sharing, and taking turns, there were no action plans to address these adaptive skills.

21-22. As described, Individual #487 became upset when there was too much noise and talking while he was watching a movie. It appeared that he appropriately moved to another viewing area, but then was followed by staff and peers. Separation of individuals was not addressed as an action plan. Individual #482's cooking SAP had been on hold for several weeks without a reason provided. When she inquired about this SAP and was told it could not be implemented, she engaged in property destruction. There was no action plan to address the reintroduction of this SAP. Individual #428 appeared to be agitated by others in his home who were displaying aggression and by one particular individual. Other than referring to administration for a possible change in the home residents, there were no other action plans identified.

24. All three individuals had a PBSP at the time of repeated restraint.

25. Individual #482 had a Crisis Intervention Plan at the time of repeated restraint. A plan was later developed for Individual #487.

26. PBSPs are reviewed in detail in the Psychology/Behavioral Health sections of this report.

27. The Crisis Intervention Plans for Individual #487 and Individual #482 were considered complete.

28. There was evidence of integrity checks for all three individuals prior to and after the dates of repeated restraint. In every case, integrity was measured at 80% or better. Concerns with assessment methods are reviewed in the Psychology/Behavioral Health sections of this report.

29. There was evidence that the PBSP was reviewed, and in Individual #482's case, revised to include criteria for a behavioral crisis.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: Indicators 2 and 3 will remain in active monitoring for potential inclusion in the next review.			Individuals:								
#	Indicator	Overall Score	264	541	7	435	212				
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A	N/A	N/A				
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A	N/A	N/A				
Comments: 2-3. Of the 16 individuals chosen by both Monitoring Teams, five were not followed by the facility's psychiatric team. All of these individuals had undergone screening with the Reiss instrument and had received scores that were below the clinical cutoff score indicating that no further action was required. During the onsite review, post Reiss, medical history of these individuals was reviewed by the Monitoring Teams and there was no indication that any had a change in status that would have required a reapplication of the Reiss screen.											

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, acknowledges 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	487	557	530	482	293	428	8	444	51
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 5/5	N/A	1/1	N/A	1/1	1/1	1/1	N/A	1/1	N/A
11	Activity and/or revisions to treatment were implemented.	100% 5/5	N/A	1/1	N/A	1/1	1/1	1/1	N/A	1/1	N/A

Comments:
8-9. It was not possible to determine if the individual was making progress because there were not existing goals with precise measurable criteria that would make this possible.

10. Even so, the records indicated that when an individual's clinical status was deteriorating, emergency/interim consults would be made and these interventions resulted in recommendations to revise their pharmacological treatment plan. The specific evidence to support this was found in the records of Individual #557, Individual #293, Individual #428, Individual #482, and Individual #444.

11. The records of these five individuals also indicated that the recommendations to increase the dosage of existing medications or switch to a different medication were implemented.

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

Summary: Psychiatric and behavioral health documents cross-referenced the relevant aspects of each others' target behaviors and their presentation. The resultant 100% score for indicator 23 showed maintained high performance from the last review, which was also improved from the previous review, too. Thus, indicator 23 will be moved to the category of requiring less oversight. Psychiatrist participation in the development of the PBSP has steadily improved compared with the last two reviews. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 487	557	530	482	293	428	8	444	51
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% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments:
23. The documentation in the psychiatric section of the record routinely referenced the behavioral aspects of the individual's presentation. The behavioral health assessment, as well as the functional assessment, described the impact of the individual's psychiatric disorder on the behavioral presentation for everyone, except for Individual #530 for whom there was a minimal discussion of the psychiatric factors in the Behavioral Health Assessment. But, the discussion of these factors in the PBSP was detailed and compensated for the lack of specific information in the Behavioral Health Assessment.

24. There are two sources of documentation of the participation of the psychiatrist in the development of the PBSP at the facility. The first of these is the Case Formulation, which is prepared by the behavior analyst and reviewed/signed by the psychiatrist. The second is the formulation of integrated treatment (FIT) section of the psychiatric treatment plan (PTP), as it is formatted in the new electronic

record. The behavioral analyst attends the psychiatric clinic during which the PTP is finalized. Both of these documents essentially contained the same information regarding the influence of the symptoms of the psychiatric disorder on the individual's behavioral presentation as it related to the development of the PBSP. The Case Formulation was gradually being replaced by the formulation section in the PTP. Within this group of individuals, all but two had either a Case Formulation or a new PTP in the electronic format that contained the formulation section. These two individuals were Individual #557, who did not have a case formulation and had not yet had a PTP developed due to his relatively recent admission, and Individual #444 who did not have a Case Formulation and his PTP was in the older written format that did not contain this specific information.

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

Summary:			Individuals:								
#	Indicator	Overall Score									
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
26	Frequency was at least annual.										
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.										

Comments:

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

Summary: Quarterly review content improved since the last review and with sustained high performance might be moved to the category of requiring less oversight after the next review. Although in less oversight, psychiatric clinics for some individuals were observed to not include behavioral data. Attention should be paid to ensure that this important aspect of psychiatric clinics occurs correctly.			Individuals:								
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
34. The content of the quarterly documentation for the nine individuals contained the required content.

35. The Monitoring Team observed the psychiatric clinics on 5/23/17 for Individual #293 and Individual #8. The observations indicated that all of the required elements of a clinical review were present. On 5/25/17, the Monitoring Team observed the psychiatric clinics for Individual #557, Individual #428, and Individual #487. These reviews contained all of the required elements, except for the presentation of the behavioral data. The specific deficits in these presentations included the lack of data presented on all of the monitored behaviors as well as the absence of graphs for all of the identified monitored behaviors.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.												
Summary: Good improvement was demonstrated compared with the last two reviews for which scores of 63% and 75% were made. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 36. Review of the data for the nine-month period indicated that the monitoring for side effects with the MOSES and AIMS was completed for each individual as per the required schedules and the prescriber review of the results occurred in a timely manner.												

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

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: Good performance was maintained. These important indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51

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

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary:			Individuals:								
#	Indicator	Overall Score									
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
45	There is a tapering plan, or rationale for why not.										
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.										
Comments:											

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.	
Summary: Given the absence of good, reliable data, progress could not be determined for all of the individuals. The Monitoring Team scored indicators 7, 8, and 9 based upon the facility's report of progress/lack of progress as well as the ongoing exhibition of problem target behaviors. The indicators in this outcome will	Individuals:

remain in active monitoring.											
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
6	The individual is making expected progress	0% 0/8	0/1	N/A	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.	50% 1/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	1/1	N/A
9	Activity and/or revisions to treatment were implemented.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A

Comments:
6. Although graphs included in the progress notes indicated descending trends for most identified problem behaviors for Individual #487, Individual #530, Individual #482, Individual #293, Individual #8, and Individual #51, this indicator was rated as zero for all nine individuals. For Individual #428 and Individual #444, their graphs depicted increases in their problem behaviors. Individual #557 was excluded from this indicator because only two months of data were provided. For all individuals, there were concerns about the reliability of the data, therefore, progress could not be determined with any confidence and zero scores were made.

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

8-9. Progress notes suggested that both Individual #428 and Individual #444 were not making progress on their targeted problem behaviors. Corrective actions were identified for Individual #444 and his most recent PBSP reflected implementation of these recommendations.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: Staff training was not occurring as much as it was at the time of the last review. Therefore, indicator 16 will remain in active monitoring. PBSPs met criteria for authorship for all individuals for all individuals for this review and for the last two reviews, too. Therefore, indicator 18 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
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.	44% 4/9	0/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

16. Documentation provided by the facility indicated that over 80% of assigned home staff had been trained in the most current PBSP for four individuals (Individual #482, Individual #293, Individual #428, Individual #51). It should be noted that staff training continued on the PBSP that had been implemented just prior to the onsite visit. Staff are advised to provide information regarding training of all day program staff who regularly work with the individual.

17. These summaries took the form of a Do's and Don'ts document that outlined key components of the PBSP. Staff are advised to date these summaries to ensure these correspond to the current PBSP.

18. For all nine individuals, there was evidence that their functional assessments and PBSPs had been written by a BCBA.

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

Summary: Useable graphs remained an area of need. Proper graphic representations of target and other behaviors are a standard expectation for behavioral health services. The same is true for reviewing all of the individual's important data during clinical meetings. These two indicators will remain in active monitoring. Implementation of recommendations from peer review were being done for all cases for this review and the past two reviews, with one exception in August 2016. Therefore, indicator 22 will be moved to the category of requiring less oversight. Documentation for some months of external peer review were not provided, but this might have been due to the change in leadership of the behavioral health department. This indicator will remain in the category of less oversight, however, the facility needs to ensure that external peer review continues to occur in order for this indicator to remain in this category.

#	Indicator	Overall Score	Individuals: 487	557	530	482	293	428	8	444	51
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	0% 0/3	0/1	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence	100%	1/1	N/A	N/A	1/1	N/A	1/1	N/A	1/1	N/A

	of documentation of follow-up and/or implementation of recommendations made in peer review.	4/4									
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

20. The graphs for two of the individuals (Individual #530, Individual #8) were determined to be useful for making data-based decisions.

21. Observations were conducted during the psychiatric clinic for three individuals, Individual #487, Individual #557, and Individual #428. Although the BCBA reviewed aggression data for Individual #487, she did not review data for his other targeted problem behaviors. No graphs were presented for the team's review. Similarly, although the BCBA reviewed data for some of Individual #557's target behaviors, not all of these were reviewed or presented in graphic format. At Individual #428's meeting, it was very positive that the BCBA had created a graph that depicted daily occurrences of aggression from 2/1/17 through 5/20/17, his other targeted problem behaviors were not reviewed.

22. There was evidence that five individuals had been reviewed by internal and/or external peer review committees. For four individuals, Individual #487, Individual #482, Individual #428, and Individual #444, recommendations had been suggested and implemented. No recommendations had been provided during the review of Individual #293's plan.

23. The facility presented evidence indicating that internal peer review meetings occurred between one to five times each month over a six-month period. Evidence was also provided that reflected two meetings of the external peer review committee over this same period of time. The director of behavioral services had recently been promoted to this position following the previous director's retirement. Difficulty locating documentation may have been a result of this transition.

Outcome 8 – Data are collected correctly and reliably.

Summary: After previous high performance in indicators 27-29, recent changes in the data collection system and electronic record resulted in criteria not being met for indicators 27 and 28 and performance decreasing for indicator 29. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 487	557	530	482	293	428	8	444	51
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
26-27. It was determined that none of the data collection systems were adequate in measuring either target or replacement behaviors during the six-month period under review. Prior to 4/1/17, data timeliness had been assessed based upon eight-hour blocks of time. Further, many of the behavioral health services staff reported concerns with data accuracy following a change in data systems.

28. For all nine individuals, it was determined that acceptable measures of IOA were in place. However, acceptable measures of treatment integrity were identified for two of the nine individuals, Individual #487 and Individual #557. Their PBSPs indicated that staff should be observed implementing the PBSP. For all others, treatment integrity could be assessed via verbal report for all or some components for the PBSP. None of the individuals had acceptable measures of data timeliness due to the assessment of data entry once every eight hours.

29. For all nine individuals, data timeliness was assessed at a minimum of once monthly. For seven individuals, the expected frequency of assessment of IOA and treatment integrity was once monthly or better. The exceptions were Individual #557 and Individual #8 who were to have these measures assessed quarterly. This was not acceptable given the recent admission of Individual #557 and the poor assessment scores for Individual #8. Expected levels were 80% or better.

30. Documents provided by the facility indicated that none of the individuals met established levels of data timeliness for targeted problem behaviors. This was true whether data were to be entered every eight hours or every two hours. For eight of the individuals, documents indicated that identified frequencies and levels for IOA and treatment integrity were met. The exception was Individual #51.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	and achievable to measure the efficacy of interventions.	0/18									
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	17% 3/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	2/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #51 – constipation/bowel obstruction, and weight; Individual #428 – seizures, and weight; Individual #172 – cardiac disease, and falls; Individual #551 – weight, and seizures; Individual #264 – cardiac disease, and weight; Individual #541 – GI problems, and cardiac disease; Individual #7 – respiratory compromise, and GI problems; Individual #435 – osteoporosis, and urinary tract infections; and Individual #212 – aspiration, and GI problems).

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 #264 – weight; and Individual #435 – osteoporosis, and urinary tract infections.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, did not include data and analysis of the data. 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: Six of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The Center should continue its efforts to ensure that 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	51	428	172	551	264	541	7	435	212

a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 5/5	N/A	1/1	1/1	N/A	1/1	1/1	N/A	1/1	N/A
	iii. Breast cancer screening	100% 3/3	N/A	N/A	1/1	N/A	1/1	1/1	N/A	N/A	N/A
	iv. Vision screen	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
	vi. Osteoporosis	86% 6/7	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1	0/1
	vii. Cervical cancer screening	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	78% 7/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments: a. Overall, the individuals reviewed generally received timely preventive care, which was good to see. The following problems were noted:

- Individual #51's last vision screen was completed on 11/6/14.
- On 10/1/14, Individual #7 had a hearing screening, which recommended recall in two years. No more recent screening was documented.
- On 12/31/15, Individual #212 had a hearing screening, which recommended recall in a year. No more recent screening was documented. In addition, her PCP documented she had no significant risk factors for osteoporosis, because she had her menses and did not take anti-epileptic drugs. However, she was immobile, placing her at increased risk.

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: Given the inconsistencies the Monitoring Team has consistently found with the Center's compliance with State Office policy, the Center should review the justifications for all individuals with DNR Orders that the Center would execute. This indicator will remain in active oversight.		Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212

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.	25% 1/4	N/A	N/A	0/1	N/A	N/A	N/A	1/1	0/1	0/1

Comments: a. Individual #172, a 59-year-old, has a lifelong congenital cardiac condition associated with a persistently prolonged QTc interval. She is followed by cardiology. She has a primary cardiomyopathy with a ventricular aneurysm. In May 2015, a pacemaker was placed. Her blood pressure is chronically low. In May 2016, and again in November 2016, she might have had chest pain, but this resolved without sequelae (she does not communicate verbally). In July 2016, aspirin was started. In January 2017, a lipid panel was unremarkable. She remains ambulatory and spry, and has refused to wear apparatus for oxygen supplementation. She currently has a DNR Order in place, which has been in place since 2002. Given her current stability, there did not appear to be sufficient justification for the Center to agree to execute the DNR Order.

For Individual #435, the 2002 justification for a DNR Order referenced "severe dysphagia and oral and pharyngeal stage of deglutition leading to poor eating/swallowing mechanism on MBS, requiring gastrostomy tube." This did not provide sufficient justification. The documentation the Center submitted included the following: "clinical justification for DNR order: irreversible condition of severe scoliosis and osteoporosis which would make chest compression ineffective and hazardous." Although this might provide justification for not using chest compressions, it is not sufficient justification for the Center to agree to execute the DNR Order.

For Individual #212, Center documentation indicated the DNR Order was due to the irreversible condition of bulbar paresis and severe dysphagia requiring enteral feeding. It also indicated: "in addition, she has irreversible respiratory fragility due to excessive secretions and chronic ileus with frequent gaseous distention which compromises her respiratory function as evident by recurrence of aspiration pneumonia with two episodes in a two-month period requiring hospitalization last year." This was particularly concerning, because as discussed in further detail below (with regard to Outcome #8), Center staff had not taken all steps necessary to assess and develop plans to address her recurrent aspiration pneumonia.

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

Summary: It was positive to see that for many of the acute illnesses reviewed that PCPs and providers conducted assessments and follow-up according to accepted clinical practice. It was concerning, though, that IDTs had not met to conduct post-hospitalization reviews. It is important for IDTs to develop, as appropriate, action steps to address follow-up medical and healthcare supports to reduce risks and promote early recognition. Except for Indicator e, these indicators will continue in active oversight.

			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
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.	67% 10/15	2/2	2/2	1/1	2/2	N/A	1/2	0/2	1/2	1/2

b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	100% 12/12	1/1	2/2	1/1	2/2		2/2	1/1	2/2	1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 11/11	2/2	2/2	N/A	1/1	N/A	N/A	2/2	2/2	2/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	90% 9/10	2/2	2/2		1/1			2/2	1/2	1/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	86% 6/7	1/1	N/A		N/A			2/2	2/2	1/2
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	0% 0/3	0/1	N/A		N/A			N/A	0/2	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% 10/10	2/2	2/2		1/1			1/1	2/2	2/2

Comments: a. and b. For eight of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 15 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #51 (vomiting on 10/18/16, and vomiting on 10/27/16), Individual #428 (fungal infection on 10/6/16, and hypertension on 10/14/16), Individual #172 (chest pain on 11/16/16), Individual #551 (dry eye syndrome on 10/12/16, and scalp lesions on 12/20/16), Individual #541 (allergic rhinitis on 12/20/16, and tachypnea on 12/28/16), Individual #7 (sedation on 11/14/16, and redness of skin folds on 1/6/17), Individual #435 (pain and vomiting on 10/26/16, and emesis on 11/20/16), and Individual #212 (bleeding from ear on 10/19/16, and hypoxia on 12/20/16).

The acute illnesses for which documentation was not present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #541 (allergic rhinitis on 12/20/16), Individual #7 (sedation on 11/14/16, and redness of skin folds on 1/6/17), Individual #435 (pain and vomiting on 10/26/16), and Individual #212 (hypoxia on 12/20/16). In these cases, the provider did not document the source of the information.

It was positive that for the acute illnesses/occurrences reviewed for which follow-up was needed, documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized.

c. For six of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses requiring hospital admission, Infirmary admission, or ED visit, including the following with dates of occurrence: Individual #51 (ED visit for hypotension and fever on 10/27/16, and Infirmary admission for dehydration on 12/6/16), Individual #428 (Infirmary admission for maceration of heel on 11/19/16, and Infirmary admission for seizure on 12/2/16), Individual #551 (Infirmary admission for hypothermia on 11/3/16), Individual #7 (ED visit for respiratory distress on 3/14/17, and hospitalization for respiratory distress on 3/15/17), Individual #435 (hospitalization for abdominal pain on 11/2/16, and ED visit for clogged J-tube on 1/19/17), and Individual #212 (hospitalization for pneumonia on 10/2/16, and hospitalization for respiratory distress on 11/12/16).

It was positive that for the acute illnesses reviewed for this indicator that PCPs or other providers assessed them timely.

d. Vital signs were not documented in the IPN for Individual #435 (ED visit for clogged J-tube on 1/19/17).

f. For Individual #212's hospitalization for pneumonia on 10/2/16, documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff.

g. It was concerning that IDTs had not met to conduct post-hospitalization reviews. It is important for IDTs to develop, as appropriate, action steps to address follow-up medical and healthcare supports to reduce risks and promote early recognition.

h. It was good to see that for the individuals reviewed, upon their return to the Center, 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: Given that over the last two review periods and during this review, for the consultations reviewed, the PCPs generally reviewed consultations and indicated agreement or disagreement (Round 10 – 100%, Round 11 – 100%, and Round 12 – 100%), Indicator a will move to the category requiring less oversight. The Center needs to focus on completing this task timely. It was good to see improvement with regard to PCPs writing orders for agreed-upon recommendations. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
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% 15/15	2/2	2/2	2/2	2/2	1/1	2/2	N/A	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	80% 12/15	2/2	2/2	2/2	1/2	0/1	2/2		2/2	1/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	100% 15/15	2/2	2/2	2/2	2/2	1/1	2/2		2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 13/13	2/2	2/2	2/2	2/2	1/1	2/2		1/1	1/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	N/A									

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #51 for colorectal surgeon on 4/5/17, and nephrology on 3/15/17; Individual #428 for orthopedics on 10/19/16, and neurology on 4/3/17; Individual #172 for cardiology on 10/13/16, and cardiology on 1/12/17; Individual #551 for neurology on 12/21/16, and neurology on 3/13/17; Individual #264 for neurology on 2/13/17; Individual #541 for neurology on 10/10/16, and cardiology on 3/20/17; Individual #435 for wound care on 1/11/17, and GI on 3/1/17; and Individual #212 for urology on 11/4/16, and ear, nose, and throat on 2/27/17.

a. It was positive that PCPs reviewed the consultation reports the Monitoring Team reviewed, and indicated agreement or disagreement with the recommendations.

b. Three of these reviews did not occur timely, including those for Individual #551 for neurology on 12/21/16, Individual #264 for neurology on 2/13/17, and Individual #212 for urology on 11/4/16.

c. It was positive that all of the PCP IPNs related to the consultations reviewed included all of the components State Office policy

requires.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments. This was good to see.

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

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

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	44% 8/18	1/2	0/2	1/2	0/2	1/2	2/2	1/2	2/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #51 – constipation/bowel obstruction, and weight; Individual #428 – seizures, and weight; Individual #172 – cardiac disease, and falls; Individual #551 – weight, and seizures; Individual #264 – cardiac disease, and weight; Individual #541 – GI problems, and cardiac disease; Individual #7 – respiratory compromise, and GI problems; Individual #435 – osteoporosis, and urinary tract infections; and Individual #212 – aspiration, and GI problems).

a. The individuals' chronic or at-risk conditions for which PCPs conducted medical assessments, tests, and evaluations consistent with current standards of care, and identified the necessary treatment(s), interventions, and strategies, as appropriate, were: Individual #51 – weight; Individual #172 – falls; Individual #264 – cardiac disease; Individual #541 – GI problems, and cardiac disease; Individual #7 – respiratory compromise; and Individual #435 – osteoporosis, and urinary tract infections. The following provide a couple of positive examples of assessment and care:

- Individual #435 was challenged due to a tendency toward renal calculi formation and risk for urinary tract infections. A local urologist initially followed him, with monitoring of urolithiasis via abdominal x-rays. Individual #435 was prescribed calcium citrate for renal calculi inhibition, hydrochlorothiazide to lower urinary calcium, and potassium citrate/citric acid solution. He was hydrated via his gastrostomy tube (g-tube). He had multiple procedures to remove renal stones from his bladder and ureters, and had ureteral stents in the past as well as lithotripsy. Despite these actions steps, he continued to develop renal calculi and renal colic. The PCP referred him to a urology specialist in Dallas. Individual #435 had a prolonged hospitalization with removal of all renal stones, with all stents removed, and placement of a jejunostomy (j-tube) with three ports. He developed post-op pneumonia and gastroparesis. Revision of the original g-tube to a j-tube was not successful, and he was discharged with a gj-tube. Since then, it was changed to a g-tube. The urology specialists in Dallas continued to follow him with review of renal sonograms and CT scans of the abdomen. As of March 2017, there was no obstructing renal calculi and he no longer had pain or vomiting. It was good to see that the PCP advocated in obtaining a second opinion to resolve his ongoing

formation and complications from renal calculi.

- The PCP calculated Individual #264's atherosclerotic cardiovascular disease (ASCVD) 10-year risk estimate and recorded it in her most recent AMA. It was 1.3%. The IDT deliberations indicated this individual was considered to have a medium risk of cardiac disease/circulatory issues/edema. She was followed by a cardiologist on an as needed basis. Currently, she took no medications to treat her cardiac disease or cardiac risk factors. On 9/18/13, she was noted to have hypertriglyceridemia. A recent lipid panel, dated 7/19/16, indicated continued elevation in triglycerides, but the total cholesterol, low-density lipoprotein (LDL), and high-density lipoprotein (HDL) were in the therapeutic/target range. She was prescribed Fenofibrate in the past, but this was discontinued due to the side effect of neutropenia. She wore compression stockings and elevated her legs to reduce dependent edema, which had been effective. She was maintained on a low salt diet. She was not a diabetic. She did not smoke. She did not have hypertension.

The following provides examples of concerns noted:

- Individual #51 had several years of significant constipation and abdominal distention. Medications prescribed included Miralax, Amitiza, Senna, docusate, magnesium citrate, bisacodyl, fiberstat, Simethicone, Beano, as well as prune juice. In December 2015, he had massive fecal retention, followed by chronic ileus. He had been prescribed Zyprexa, but on 3/22/16, it was discontinued, with no subsequent anti-psychotic medications administered at that time. In April 2016, he underwent a decompressive colonoscopy. The chronic ileus/repeated small bowel obstruction could not be treated medically, and in October 2016, resulted in a total colectomy with end ileostomy. Post-surgically, he developed gastroparesis with vomiting. He continued to have chronic ileus, bloating, and intermittent vomiting, and began to prefer a liquid diet. He was not able to cooperate for an upper GI series. He was intermittently administered intravenous hydration due to fluid refusal and projectile vomiting. There was ongoing communication with the surgeon to rule out other causes of vomiting and anorexia. His appendix had been removed, and his gall bladder was considered functional without problems. Pancreatitis was ruled out. He had urologic problems that had been treated with nitrofurantoin, but this medication led to a chemical hepatitis, with resolution once it was discontinued. On 1/4/17, Reglan was ordered, and a GI consult was requested to consider a g-tube. With recurrent small bowel obstruction, he underwent an exploratory laparotomy and revision of the ileostomy. Extensive abdominal adhesions were found. His post-operative course was complicated by a pelvic abscess that was treated at a long-term acute care facility. He lost considerable weight and was considered malnourished. He was treated with additional intravenous nutrition. The PCP and IDT advocated for a third surgical opinion. More recently, a colo-rectal surgeon in Dallas was consulted and was following this individual. According to the PCP, Individual #7's last episode of vomiting was on 3/19/17, but other data suggested he had ongoing vomiting. The PCP had not been involved in some ISP/ISPA meetings, and it appeared the IDT might not have invited the PCP to such meetings. The lack of communication and discussion regarding the impact that his long stay at the Infirmary was having on his quality of life issues remained problematic. In addition, it did not appear critical clinical discussion had occurred among Neurology, Pharmacy, Behavioral Health Services, Residential Services, and the PCP to review medications that might be aggravating his GI health, or alternative medications that might assist in his recovery. The PCP's IPNs were thorough and reflected a level of diligence. However, the PCP needs to play an important role in the interdisciplinary coordination of healthcare services, and the "silo" effect of non-communication among disciplines seemed to negatively impact the treatment of this individual. Concerns related to the accuracy of data collection and communication of data in relation to vomiting also likely was having a negative impact.

- Individual #7 had both upper and lower lifelong gastrointestinal diagnostic and therapeutic challenges. For his diagnosis of gastroesophageal reflux disease (GERD) and hiatal hernia, he underwent a Nissen fundoplication in 1988, and placement of a g-tube. There were complications from the g-tube (i.e., a gastric fistula requiring resection as well as small bowel obstruction when it migrated to his small bowel in 2005). In August 2013, an esophagogastroduodenoscopy (EGD) report stated there was no esophageal inflammation and the fundoplication was intact. In December 2015, Individual #7 was noted to have significant gastroparesis with high gastric residual. He was treated with Metoclopramide. He also had significant constipation, eventually resulting in October 2015, in a total colectomy with ileostomy placement for his chronic ileus and colonic inertia. For his GERD, he also was treated with head-of-bed elevation and medication (Omeprazole). There was no ongoing evaluation of his gastroparesis to determine if other treatment considerations were needed (e.g., placement of j-tube, or both j-tube for feeding and g-tube for medication use or to relieve gastroparesis). The fundoplication was last checked in 2013, and in the documentation submitted, there was no indication it had been re-assessed since that time to determine if it had unwrapped. The individual's feeding rate appeared to be intermittent rather than continuous, and no explanation was provided for this decision in the documentation submitted. These concerns, unless monitored on an ongoing basis, could contribute to reflux with aspiration, causing respiratory distress. The submitted documentation did not provide information about these concerns. On 3/16/17, Individual #7 died at the age of 53 with cause of death listed as aspiration pneumonia.

- Individual #212 had a long history of severe GERD, which improved in 1986, following surgery for a hiatal hernia repair and Nissen fundoplication. On 3/12/15, she underwent an upper GI series through her g-tube to determine the extent of reflux. Despite positioning maneuvers, no GERD was found at that time. The PCP made a recent diet change to lower caloric intake, and reduced the feeding rate. Documentation was not found to explain why further evaluation did not occur for gastroparesis that might aggravate reflux when the stomach is full. There was no plan to repeat an upper GI series or EGD to determine whether the fundoplication was intact. Given that the severity and frequency of her respiratory distress continued, ongoing /periodic evaluation was indicated. Communication with the PNMT and Habilitation Therapies Department also should occur to ensure optimal positioning during activities, medication administration, tube feeding, and bathing, as well as aggressive frequent monitoring of positioning.

  In addition, Individual #212 had a history of aspiration pneumonia, interstitial pneumonitis, acute respiratory distress, and acute respiratory failure. An internal review, dated 10/3/16, indicated that leaving the home might have exposed her to environmental allergens with subsequent reactive airway disease. The guardian agreed that she should not leave the home when the pollen count was medium to high. On 11/12/16, her acute respiratory distress was associated with vomiting from urosepsis. The 12/15/16 PNMT report recommended: 1) consulting respiratory therapy to increase the frequency of her breathing treatments during high pollen months; 2) a review of medication by the clinical pharmacist; 3) a Habilitation Therapies assessment of positioning for promoting expectoration; 4) increased monitoring for positioning compliance; and 5) allergy testing. On 12/30/16, PNMT monitoring did find concerns with staff compliance with PNMP requirements. Allergy testing was done, but results were negative. On 3/24/17, the PCP did not attend the post-hospital ISPA meeting. The report stated: "team concern: she should have been treated quicker with medications to help prevent illness. She was ill 3 full days only taking breathing treatment and or other medications. Team members would like for early measures to be considered… Team would like a proactive approach. Team wants early and aggressive intervention…" Based on interview, the PCP was not

aware of the contents of this ISPA, indicating not only that the PCP had not attended the meeting, but had not read the report. With regard to this hospitalization for respiratory distress, it was not clear what additional steps should have been taken clinically, but there was frustration among team members who needed questions answered. In addition, as discussed above, based on documents submitted, the PCP had not identified or planned additional steps to address her continued frequent aspiration pneumonia and aspiration pneumonitis.

- Individual #428 had a seizure disorder and had complications from the seizures as well as the treatment of seizures. In December 2016, he had an unwitnessed seizure, with aspiration, after which he developed hypoxia and aspiration pneumonia. He subsequently changed neurologists, and continued to see the neurologist who provided care during the hospitalization. A number of medication dosage changes were made. He was found to have a high ammonia level, which is a potential contributor to falls, gait instability, and mental status changes, and Valproic Acid (VPA) was discontinued because of this finding. No subsequent ammonia level was found in submitted documents to confirm the VPA had caused this effect, or to determine whether ammonia levels remained elevated. Other medications prescribed included Lacosamide, Lamotrigine, Levetiracetam, and Phenobarbital. Vitamin B6 was added, and the PCP pursued obtaining an opinion concerning the benefit of a vagus nerve stimulator (VNS). Currently, Individual #428 was to have completed an appointment with a neurosurgeon, but the PCP was not aware of any report or if the appointment had taken place. Over the past two years, Individual #428 had an increase in the number of falls, and the role of seizures in contributing to the falls was not clear. The PCP did not address the falls in a plan of care. Individual #428 fractured a leg during a fall in the mud, but it was not clear if this also involved other circumstances, such as a seizure. The role of side effects from the seizure medication polypharmacy in contributing to falls was potentially significant, but the PCP did not discuss it in the plan of care. Although the PCP and IDT appeared to be advocating for the individual in obtaining further management of the seizure disorder from additional specialists, pieces were missing from the overall management of this risk area.

  In addition, Individual #428 was 41% above his recommended weight range. In the prior year, he lost nine pounds, but current weights indicated he had no further significant decline over recent months. In addition, weight measurements per month greatly vacillated, making the data difficult to interpret. Individual #428 was not allowed to use table salt, and was prescribed a 2200 calorie per day diet. However, his family brought him meals and snacks two to three times per month. He was prescribed Losartan to control his blood pressure and Simvastatin to control his dyslipidemia. On 12/20/16, his HDL was 55. On 5/10/17, his albumin was 4.2 and fasting blood sugar was 87. He had several risks of metabolic syndrome, including hypertension, hyperlipidemia, and abdominal girth. Two of these risks were currently controlled. However, weight was not controlled. He was not able to ambulate for several months due to his leg fracture, but now was able to ambulate. The immobility was assumed to have contributed to his five-pound weight gain over two months. Although he now resumed ambulation, there was no formal exercise program to assist in weight loss. The submitted documents did not indicate family counseling concerning his weight as a health risk, and snack choices that would be beneficial for the family to provide to him.

- Individual #551 had quadriplegia from pathology in his cervical spine. He also had spasticity in both arms and flaccid paralysis of his legs. Due to immobility, he has dependent edema of his legs. The Center submitted somewhat differing data, but since his admission in June 2014, he gained approximately 57 pounds. His ability to complete an exercise regimen was limited. The PCP prescribed a 2200 calorie diet. On 10/6/16, the PCP changed his diet to 1200 calories per day. The PCP adjusted his thyroid

	medication upward, although the rationale was not well documented based on lab values the PCP recorded and the QDRR stated. An endocrinology consult might be needed to ensure optimal thyroid treatment. The plan of care in the AMA did not address his weight. He is cooperative with physical therapy, which includes use of a tilt table and passive range of motion for both upper extremities, and bilateral arm extension braces. He is prescribed several muscle relaxants (baclofen, methocarbamol, and diazepam), as well as aripiprazole. The IHCP mentioned "encouragement" to make healthy food choices, but provided no information as to how this was done, or what instructions were provided to him, and/or reinforcement of this information. The PCP needed to lead the IDT in determining the history and etiology/cause of his rapid weight gain subsequent to admission, and in developing additional steps to reverse his weight gain.

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. However, documentation generally was found to show implementation of those few action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	75% 3/4	N/A	N/A	N/A	1/2	N/A	2/2	N/A	N/A	N/A

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed generally were implemented.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; 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

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									

Comments: 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: Since the last review, it was good to see improvement with regard to the quality of the QDRRs. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	94% 17/18	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	100% 9/9	N/A	1/1	N/A	2/2	2/2	N/A	2/2	N/A	2/2
	iii. Medication polypharmacy;	81% 13/16	N/A	2/2	2/2	2/2	2/2	1/2	2/2	2/2	0/2
	iv. New generation antipsychotic use; and	100% 6/6	2/2	2/2	N/A	2/2	N/A	N/A	N/A	N/A	N/A
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	80% 4/5	N/A	N/A	1/1	N/A	N/A	2/2	N/A	1/2	N/A
e.	If an intervention indicates the need for a change in order and the	N/R									

	prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.										

Comments: b. Overall, in comparison with the two previous reviews, improvement was noted with regard to the quality of the QDRRs. Some of the concerns noted included:

- For one individual, the most recent lab data available had not been incorporated into one of the QDRR reports.
- In three QDRRs, polypharmacy was not recognized and addressed.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation generally was presented to show they implemented them. The exception was for the 11/18/16 QDRR for Individual #435 that recommended discontinuation of calcium carbonate, and start of calcium citrate. The PCP did not complete this recommendation until after the Clinical Pharmacist made a second recommendation in the next QDRR.

Dental

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

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

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	20% 1/5	0/1	N/A	N/A	0/1	0/1	N/A	0/1	N/A	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	40% 2/5	0/1	N/A	N/A	0/1	1/1	N/A	0/1	N/A	1/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/5	0/1	N/A	N/A	0/1	0/1	N/A	0/1	N/A	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/5	0/1	N/A	N/A	0/1	0/1	N/A	0/1	N/A	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5	0/1	N/A	N/A	0/1	N/A	N/A	0/1	N/A	0/1

Comments: a. and b. Individual #172 and Individual #541 were edentulous, and were part of the outcome group, so a limited review was conducted. Individual #428 and Individual #435 were at low risk for dental issues, so no goals/objectives were necessary. They were part of the core group, so full reviews were conducted. The Monitoring Team reviewed five individuals with medium or high dental risk ratings. Individual #212 had a clinically relevant, achievable, and measurable goal/objective related to dental.

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to

measure the individual's progress or lack thereof: Individual #264's goal/objective for direct support professional staff to brush her teeth. This was inconsistent with information in her IRRF that indicated she could brush her own teeth, but needed assistance to ensure she did a thorough job. The IRRF also indicated that the team agreed to implement a SAP for Individual #264 to turn on her toothbrush. This SAP was not specifically stated and carried forward in the IHCP. Either this SAP or a SAP to improve the thoroughness of her brushing would have assisted her in gaining independence with tooth brushing.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, often did not include data and analysis of the data. 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.

Outcome 4 – Individuals maintain optimal oral hygiene.

Summary: The Monitoring Team will continue to review these indicators.

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	Individuals have no diagnosed or untreated dental caries.	100% 7/7	1/1	1/1	N/A	1/1	1/1	N/A	1/1	1/1	1/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	100% 5/5	1/1	1/1	N/A	1/1	N/A	N/A	1/1	1/1	N/A
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1
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 #172 and Individual #541 were edentulous. It is important to point out that these findings indicate that all but the two edentulous individuals had gingivitis or a more severe form of periodontal disease.

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

Outcome 5 – Individuals receive necessary dental treatment.

Summary: It was positive that for the individuals reviewed, the Dental Department provided prophylactic care, tooth-brushing instruction, and x-rays in a timely manner. Given that over the last two review periods and during this review, the Dental Department completed x-rays in accordance with current standards for the	Individuals:

individuals reviewed (Round 10 – 100%, Round 11 – 83%, and Round 12 – 100%), Indicator c will move to the category requiring less oversight. Work is needed to ensure individuals who need it receive fluoride treatment, and treatment for periodontal disease.											
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
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% 5/5	N/A	1/1	N/A	1/1	1/1	N/A	N/A	1/1	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 7/7	1/1	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.	100% 7/7	1/1	1/1		1/1	1/1		1/1	1/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	33% 1/3	0/1	N/A		N/A	1/1		0/1	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.	50% 1/2	N/A	N/A		N/A	0/1		N/A	N/A	1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	N/A									
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									
Comments: a. through f. Individual #172 and Individual #541 were edentulous.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: When dental emergencies occur, better nursing and/or dental documentation is needed with regard to the onset of symptoms. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A	N/A								

c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A	N/A								
Comments: a. through c. On 1/18/17, the dentist saw Individual #51 on an emergency basis. It was unclear, though, when the need was first identified. No treatment or pain management was necessary.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	20% 1/5	0/1	N/A	0/1	N/A	N/A	N/A	0/1	0/1	1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/5	0/1		0/1				0/1	0/1	0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	60% 3/5	0/1		1/1				1/1	0/1	1/1
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% 0/5	0/1		0/1				0/1	0/1	0/1
Comments: None.											

Outcome 9 – Individuals who need them have dentures.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: For the individuals reviewed with missing teeth, dentures were not recommended.											

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 staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed significant improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
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.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1
f.	The individual's acute care plan is implemented.	0% 0/8	0/1	0/1	0/1	0/1		0/1	0/1	0/1	0/1

Comments: a. through f. Nursing Administration at ABSSLC indicated that, even with the conversion to IRIS, nursing staff developed and implemented acute care plans for applicable acute illnesses and events. Based on the documents submitted, a number of individuals had acute events and illnesses or events that warranted acute care plans, but for which nursing staff had not developed and/or implemented acute care plans. In addition, those acute care plans that nursing staff did develop did not meet the individual's needs and were not consistent with current standards of care. The following provide some examples of concerns noted:

- Individual #428 experienced the following acute events that warranted acute care plans, but for which none were submitted: on 10/6/16, a fungal infection to folds of neck; on 11/19/16, a right heel maceration; in October 2016, an increase in blood pressures with lower leg edema requiring an increase in blood pressure medication; and between 10/31/16 to 4/19/17, ongoing episodes of vomiting (i.e.,16 episodes); and
- Acute care plans submitted did not include measurable interventions or complete criteria for assessments, and/or did not

specify the frequency of implementation of the interventions, staff responsible for implementation, where interventions would be documented, and how often and who would review them for effectiveness/modification.

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.

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2	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 #51 – skin integrity, and constipation/bowel obstruction; Individual #428 – GI problems, and falls; Individual #172 – falls, and UTIs; Individual #551 – weight, and constipation/bowel obstruction; Individual #264 – weight, and falls; Individual #541 – constipation/bowel obstruction, and UTIs; Individual #7 – cardiac disease, and fractures; Individual #435 – weight, and choking; and Individual #212 – skin integrity, and fractures).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #435 – weight, and choking.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports, including data and analysis of the data, were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the 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 four 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	51	428	172	551	264	541	7	435	212
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% 0/12	0/2	0/2	0/2	N/A	0/2	0/1	0/1	0/1	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: As noted above, the Monitoring Team reviewed a total of 18 specific risk areas for nine individuals, and as available, the IHCPs to address them.

a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was 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.

The following provide examples of concerns related to teams' inaction to address individuals' needs:

- Individual #51 experienced weight loss, decreased intake and output, and had pneumonia, sepsis, at least 17 episodes of emesis, and bowel obstructions. On 3/28/17, the PT assessed him for endurance due to severe emaciation. All of these issues placed him at high risk for skin issues. The IDT did not modify the IHCP to include a goal for skin integrity and/or develop interventions to ensure nursing staff proactively assessed him to prevent skin breakdown.

  Similarly, Individual #51 had issues with constipation progressing to impactions, bowel obstructions, and ileus. The IDT did not implement any proactive nursing assessments and monitoring of his bowel status up until the time he had an ileostomy.
- For Individual #428, the data the Center provided in response to the Monitoring Team's request indicated that he had at least 12 episodes of emesis from 10/31/16 to 2/9/17. However, this data was not reflected in the IRRF, PNMT report, Active Problem List, and/or Nursing documentation. As a result, it appeared that the IDT had not identified his vomiting as a significant problem and a variable to his other risks factors of weight, constipation, and skin integrity, and perhaps falls. The Integrated QIDP reviews noted some of the episodes, but did not identify this as an issue for further analysis.
- On 11/19/16, Individual #428's right foot was white, wrinkled, non-blanchable (i.e., unable to check circulation), and foul smelling from wearing a wet orthro boot. Direct support professional staff and nursing staff should have been checking this

every shift and had not been for his foot to have gotten to the condition it did. However, the IDT put no proactive monitoring in place to prevent a recurrence.

- For Individual #428, the initial data the Center provided to the Monitoring Team only reflected two falls in the past six months. However, when asked for data for the past year, 39 dates were provided indicating that he had 39 falls during the past year. The Center indicated that this revised information was collected by reviewing the IPNs, which meant staff could not easily aggregate this data from the electronic health record. Moreover, the IDT had not defined the different type of falls or analyzed data to help determine why he falls. Even after he fractured his leg, the IDT did not modify the IHCP to include regular nursing assessments to proactively address falls.
- Individual #172's IDT had not developed or implemented a plan focused on prevention of UTIs. In the IRRF, there was no mention of the organisms from past UTIs to indicate what the causes of the UTIs were and provide information on how to prevent them. She was on a fluid restriction due to her cardiac issues related to Congestive Heart Failure, so identifying the cause or possible cause of the UTIs was essential.
- On 10/4/16, Individual #264's IDT developed a SAP for exercising using a stationary bike for five minutes to extend to 30 minutes per day. However, according to the QIDP monthly reviews, it was not initiated until March 2017. Individual #264's current diet was 1000 calories per day, which was a significantly restrictive diet, but she had gained weight. There was no indication that the IDT collaborated with her family to accurately calculate her caloric intake and/or enlist the family in providing heathy food choices while she is at home.
- Although Individual #7 sustained a fracture of the right distal femur in August 2015 and had significant osteoporosis (i.e., DEXA Scan showed -7.3 of the lumbar spine, and -5.6 right total hip), the team did not implement any monitoring of staff transfers to ensure staff were moving him safely.

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

Summary: For the two previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; and 2) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.

#	Indicator	Overall Score	Individuals: 51	428	172	551	264	541	7	435	212
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									

c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	33% 1/3	N/A	N/A	N/A	N/A	N/A	0/1	N/A	0/1	1/1
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	25% 1/4	0/1	0/1	N/A	N/A	N/A	N/A	N/A	0/1	1/1
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	25% 2/8	0/1	1/1	0/1	0/1	1/1	0/1		0/1	0/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8	1/1	0/1	1/1	1/1	1/1	1/1		1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

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

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #51, Individual #428, Individual #172, Individual #551, Individual #264, Individual #541, Individual #435, and Individual #212.

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

d. The CNE reported that nursing staff completed training regarding lung sounds during medication administration in alignment with the indicators. The following concerns were noted:

- For Individual #51, the medication nurse assessed lung sounds before and after medication administration, which was good to see. However, the acute care plan did not include information about where nursing staff would document lung sounds obtained during medication administration.
- In December 2016, Individual #428 was diagnosed with aspiration pneumonia. The medication nurse did not assess lung sounds before and after medication administration.
- Individual #541 was at high risk for aspiration, but the IHCP did not include regular assessments of lung sounds.
- Individual #435 began coughing during medication administration, but the medication nurse did not assess lung sounds. In addition, Individual #435's IHCP called for monthly lung sound assessments, which was not sufficient given the individual's high risk for aspiration.

f. Often, medication nurses did not use the individuals' PNMP pictures and check the position of the individuals prior to medication administration.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was the nurse that touched the eyedropper to Individual #428's eye, which contaminated the bottle and then contaminated his other eye when the drops were administered.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.	
Summary: It was good to see some improvement with regard to individuals being referred to the PNMT, when needed (i.e., during the review, the Center's score was 38%). Overall, though, IDTs and/or the PNMT did not have a way to measure	Individuals:

outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.											
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	N/A	N/A	0/2	0/2	0/2	0/1	0/1	N/A	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/9			0/2	0/2	0/2	0/1	0/1		0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9			0/2	0/2	0/2	0/1	0/1		0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/9			0/2	0/2	0/2	0/1	0/1		0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/9			0/2	0/2	0/2	0/1	0/1		0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	78% 7/9	2/2	1/2	N/A	N/A	N/A	0/1	1/1	2/2	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/2	0/2				0/1	0/1	0/2	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/9	0/2	0/2				0/1	0/1	0/2	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9	0/2	0/2				0/1	0/1	0/2	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/9	0/2	0/2				0/1	0/1	0/2	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/2	0/2				0/1	0/1	0/2	0/1
Comments: The Monitoring Team reviewed nine goals/objectives related to PNM issues that six individuals' IDTs were responsible for											

developing. These included goals/objectives related to: choking, and aspiration for Individual #172; choking, and skin integrity for Individual #551; choking, and falls for Individual #264; aspiration for Individual #541; choking for Individual #7; and choking for Individual #212.

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

b.i. The Monitoring Team reviewed nine areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included: GI problems, and weight for Individual #51; aspiration, and fractures for Individual #428; fractures for Individual #541; aspiration for Individual #7; weight, and aspiration for Individual #435; and aspiration for Individual #212.

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

- The PNMT conducted a timely review of Individual #428's fracture. However, in December 2016, when he diagnosed with pneumonitis, the PNMT did not conduct a review, and indicated the reason was he did not have pneumonia. However, pneumonitis can be caused by pneumonia, GERD, reflux, etc. Therefore, at least a PNMT review was warranted.
- The PNMT did not conduct a review of Individual #541's long bone fracture that occurred on 8/30/16.

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

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	45% 5/11	2/2	0/2	N/A	0/1	0/1	0/1	0/1	2/2	1/1
c.	If an individual has been discharged from the PNMT, individual's	0%	0/2	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1

	ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0/4									

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Even for the action steps included, little documentation was found to confirm their implementation.

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

- Although Individual #428's IDT referred him to the PNMT timely after his fracture (i.e., 5/10/17), they did not refer him earlier despite the fact that his falls began increasing in March 2017, and the IDT did not take sufficient action themselves to identify the underlying cause(s) of this change in status.
- During December 2016 and January 2017, Individual #264 fell three times in less than a 30-day period, but the Center provided no evidence that the PT was notified and/or that the PT completed a consult.

c. For Individual #51 and Individual #428, no ISPA documentation was found to show the PNMT met with the IDTs for purposes of discharge from the PNMT. Individual #212's discharge was noted in PNMT notes, but the notes provided no detailed summary showing that all action items were completed, the result of the action items, and how her IHCP(s) was modified.

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.	31% 15/48
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.	0% 0/5

Comments: a. The Monitoring Team conducted 48 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 13 out of 30 observations (43%). Staff followed individuals' dining plans during two out of 17 mealtime observations (12%). Staff completed transfers correctly during none out of one observations (0%).

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
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.	50% 1/2						0/1	1/1	N/A	N/A
Comments: a. As noted above, while an assessment was conducted to determine the feasibility of Individual #541 returning to oral intake, a plan was lacking that would assist her down the path to where enteral nutrition was not required. It was positive that evidence was present to show Individual #7's plan was implemented prior to his death.											

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: It was good to see that some OT/PT goals/objectives developed for individuals reviewed were clinically relevant, and measurable. However, for the individuals reviewed, IDTs overall did not have a way to measure outcomes related to formal OT/PT services and supports, and for a number of individuals, IDTs had not developed OT/PT goals/objectives when they should have. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	38% 3/8	0/1	1/1	0/1	2/2	0/1	0/1	0/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	38% 3/8	0/1	1/1	0/1	2/2	0/1	0/1	0/1		
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	13% 1/8	0/1	1/1	0/1	0/2	0/1	0/1	0/1		
d.	Individual has made progress on his/her OT/PT goal.	13% 1/8	0/1	1/1	0/1	0/2	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% 0/8	0/1	0/1	0/1	0/2	0/1	0/1	0/1		
Comments: a. and b. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual											

#428 (i.e., By 2/18… will walk independently for 15 minutes for 5 consecutive sessions), and Individual #551 (hitting the ball while extending his arms, and displaying greater than 105 degrees of elbow extension).

The following provide examples of concerns related to the lack of goal development and/or the provision of OT/PT interventions:

- The OT/PT assessment as well as ISPAs stated that Individual #51 had been severely deconditioned. This was noted in the OT/PT consult, dated 3/31/17, but the IDT did not develop a goal or other strategy to recondition him. The only action the IDT took was to implement a gait belt.
- According to Individual #172's 2017 OT/PT update, she had an increase in falls and a physical decline. However, the IDT did not develop a goal/objective.
- Individual #264's IDT noted an increase in falls and an unsteady gait. No therapy was initiated, nor was justification provided for not initiating therapy.
- Individual #541 had significant issues with contractures, yet no passive range of motion program was implemented to prevent further tightening of her muscles and joints.
- It was unclear whether or not Individual #435 or Individual #212 should have had goals/objectives developed. As discussed in the assessment section, their assessments were old, and it appeared they had experienced changes in status.

c. through e. Although Individual #428 made some progress on his goal, he had not achieved it, and in April 2017, the PT discontinued it. The justification for this decision was unclear, given that Individual #428 still had issues related to strength and balance, and he continued to experience falls. Individual #428 was in the core group, so a full review was conducted. Individual #435 and Individual #212 also were part of the core group.

In addition to a lack of clinically relevant and achievable goals/objectives, integrated progress reports did not include data and analysis of the data for the few goals/objectives that IDTs had included in ISPs/IHCPs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	57% 4/7	N/A	0/1	N/A	1/2	2/2	1/1	0/1	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	33% 1/3	N/A	0/1	N/A	0/1	N/A	1/1	N/A	N/A	N/A
Comments: a. Some problems noted included:											

- In February 2017, Individual #428's PT recommended a walking program, but in April 2017, the IDT discontinued the goal. The reason for discontinuing it was that Individual #428 was independent. The concern was that he continued to have falls and the issue the goal was addressing was not his independence, but improving his stability and strength.
- Individual #551 had multiple goals related to range of motion, but the monthly notes did not specify to which goal/objective the data referred.
- For Individual #7, no evidence was found of implementation of the plan to sustain eye contact to help with his head/neck strength.

b. ISPA documentation was not submitted to show meetings to discuss discharge from therapy for Individual #428 or Individual #551.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 10 – 71%, Round 11 – 63%, Round 12 - 91%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for this indicator, scores continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	373	443	335	521	314	395	506	76	71
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	91% 31/34	1/1	1/1	1/1	1/1	1/1	2/2	1/1	1/1	2/2
		Individuals:									
#	Indicator		236	480	282	311	555	435	337	377	347
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		382	368	525	203	250	401	150	349	166

c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	2/2	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		51	198	505	215					
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1					
Comments: c. The Monitoring Team conducted observations of 34 pieces of adaptive equipment. Based on observation of Individual #311 and Individual #347 in their wheelchairs, the outcome was that they were not positioned correctly. In addition, Individual #236's palm protector did not provide the needed support. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.											

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

This Domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition, and communication. At the time of the last review, none of the indicators moved to the category requiring less oversight. Presently, one of these indicators in the area of skill acquisition will move to the category requiring less oversight.

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

In order to determine if individuals are making progress towards achieving their ISP personal goals, implementation and data are required. Action steps were not regularly and correctly implemented for all goals and/or action plans for any of the individuals. Given the amount of work that goes into preparing for the ISP and developing goals and action plans, implementation and data/documentation are priorities for Abilene SSLC.

Direct support staff were generally able to describe individual's health and behavioral risks, which was good to see. Their knowledge regarding the goals and content of individuals' ISPs, however, was insufficient to ensure the implementation of the ISP.

SAPs did not have reliable data so that progress could be determined. For those SAPs for which the Center reported no progress, no actions were taken to modify the SAP. SAPs were missing many components; none had all of the required components. Correct implementation of SAPs must be ensured. SAPs that the Monitoring Team observed were not done correctly.

It was good to see that goals for engagement were established. Meeting these goals had not yet been achieved. Goal frequencies of recreational activities in the community were established, but not achieved. SAP training in the community was not occurring at all.

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Implementation and data are required if this set of indicators is to be determined. Given the amount of work that goes into preparing for the ISP and developing goals and action plans, implementation and data/documentation are priorities for Abilene SSLC. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	428	487	8	435	172			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
Comments: 4-7. Overall, personal goals did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37, for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans. For the personal goals that met criterion with indicators 1 and 2, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available.											

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	428	487	8	435	172			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
Comments: 39. While direct support staff were generally able to describe individual's health and behavioral risks (this was good to see), staff											

knowledge regarding individuals' ISPs was insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans for any of the individuals, as noted throughout this report. Examples of action plans that were never implemented included:

- Individual #51's action plans to choose an activity, go on a nature walk with a friend, send a card to his brother, trial to remove his brief, and to attend a provider fair.
- Individual #428's action plans to go to Primetime to bowl, make cards to send to his sister, to be assessed for janitorial tasks, to shop for clothing, and to attend community education tours.
- Individual #8's goal to shop for a camera and record player, go to a concert with a peer, open a savings account, and go on community tours.
- Individual #487's action plans for swimming, adding another class at school, and using his Dynavox at school.
- Individual #435's action plans to choose a community activity, go on a community outing with a friend, consultation with the vocational program, and select an item that he wants to buy at a store.
- Individual #172's action plan to shop for art supplies, choose between activities, and shop for shoes.

Skill Acquisition and Engagement

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

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

#	Indicator	Overall Score	Individuals: 487	557	530	482	293	428	8	444	51
6	The individual is progressing on his/her SAPS	0% 0/22	0/3	N/A	0/3	0/3	0/2	0/3	0/3	0/3	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/16	0/3	N/A	0/2	0/3	0/1	0/3	0/1	0/3	N/A
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. Progress was not evident for any of the SAPs. Data provided indicated that progress was not being made on 18 of the 26 SAPs. Four SAPs were rated as not progressing due to the lack of reliable data. Lastly, there were insufficient data (i.e., less than three months) to assess progress on four SAPs,

7. None of the goals had been met.

8. There was no evidence of actions taken when the individual was not making progress on his/her SAP.

9. There was evidence that data were reviewed when determining whether to continue, discontinue, or modify SAPs.

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

Summary: SAPs were missing many components; none had all of the required components. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 487	557	530	482	293	428	8	444	51
13	The individual's SAPs are complete.	0% 0/26	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/2

Comments:
13. None of the SAPs were considered complete. The majority did have relevant discriminative stimuli, specific consequences for incorrect responding, task analyses where appropriate, behavioral objectives, operational definitions, instructions for teaching the skill, and plans for maintenance and generalization.

Also missing were teaching schedules that would allow for sufficient opportunities to develop the skill, the use of individualized reinforcement, and adequate descriptions of documentation methodology (e.g., many SAPs guided the instructor to follow the cues in Care Tracker).

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. The facility had implemented a plan to regularly assess the quality of implementation, but there was no confidence in their positive findings given the direct observations conducted by the Monitoring Team. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 487	557	530	482	293	428	8	444	51
14	SAPs are implemented as written.	0% 0/4	N/A	N/A	N/A	0/1	N/A	0/1	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.	46% 12/26	3/3	0/3	0/3	3/3	2/3	0/3	1/3	2/3	1/2

Comments:
14. The facility scheduled SAP observations for eight individuals. Individual #51 was not scheduled because his SAPs were on hold

while he was in the infirmary. Three individuals, Individual #487, Individual #557, and Individual #293, either refused to participate or were otherwise engaged. Individual #530 had already completed the step to be observed when the Monitoring Team arrived to his home. It should be noted that he completed several additional steps in this chain, suggesting a probe should be conducted to determine his current skill level. Additionally, staff should consider using an adapted cookbook (e.g., "Look and Cook) or creating adapted recipes so that he can be more independent in making gluten free baked goods.

Individual #482 completed two math worksheets (totaling different monetary amounts) without the use of the calculator and accessed her reinforcement box upon conclusion of the SAP. Although the discriminative stimulus identified in the SAP was not used, the initial instruction was appropriate to the task. Again, it may be appropriate to probe the final skill level, because it appeared that Individual #482 was very capable of completing the current step.

The staff member working with Individual #428 asked him to point to four different coins, while the current step required him to identify the penny only. She did rearrange the coins between trials, used praise and other forms of positive feedback (e.g., high five), and implemented correction trials appropriately. The materials used were oversized paper depictions of coins. This will require the individual to generalize this skill to actual coins to make this a useful skill. When the director of behavioral health services was asked about this SAP, she explained that there were restrictions of using actual money.

Individual #8's SAP was implemented as written, however, the identified reinforcer was not delivered contingent upon her correct response. Gum was going to be given to her following her breakfast. Staff are advised to reword the definition of Lupus because she has difficulty reading one word.

Individual #444 named pictures of items after the staff member identified the categories to which they belonged. It was not clear that Individual #444 was learning the concept of categories. The reinforcer identified in the SAP was not provided contingent upon correct labeling. As described by the director of behavioral health services, staff must first check the electronic record to identify the current step of the SAP. This required increased effort for the staff member and may compromise correct SAP implementation. In the future, the SAP documents will include the current step only.

15. There was evidence that SAP integrity had been assessed once over a six-month period for 14 of the 26 SAPs. Reports indicated that integrity was assessed at 80% or better in 12 of these SAPs. These measures did not correspond to the integrity assessments completed by the Monitoring Team during SAP observations during the onsite week, thus, questioning the reliability of the facility's findings.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: These two indicators received high scores on this review and 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.			Individuals:								
#	Indicator	Overall	487	557	530	482	293	428	8	444	51

		Score									
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.	100% 26/26	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	2/2

Comments:
16. There was evidence that all 26 SAPs were reviewed monthly. These reviews were data-based.

17. Graphs depicting progress were provided for all of the SAPs reviewed.

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

Summary: It was good to see that goals were established. This has been the case at Abilene SSLC for some time now and, therefore, this indicator (20) will be moved to the category of requiring less oversight. Similarly, the facility has been measuring engagement (indicator 19) and with sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. Obtaining/achieving better engagement is the important outcome monitored in indicators 18 and 21 and or which much work is still needed. These three indicators (18, 19, 21) will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 487	557	530	482	293	428	8	444	51
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	0/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18. Levels of engagement varied across the individuals. Individual #530, Individual #482, and Individual #428 were consistently engaged when observed by the Monitoring Team.

While staff were observed interacting with Individual #487 and Individual #557, they were often not meaningfully engaged. This was particularly concerning because they had few structured activities either on or off campus as they began their summer vacation from school.

Individual #293 and Individual #444 were not engaged on their homes and they both were reported to refuse to participate in their scheduled work activities. Individual #8 was engaged while at work, but was often in her room when she was visited on her home. Individual #51 was in the infirmary where most of his programming had been suspended. It would be advisable to develop a clear plan for his transition back to his home and other environments.

19-21. The facility had developed a system for regularly reviewing (i.e., monthly) engagement across home, work, and day program sites. In the homes of the individuals in the review group, engagement goals were between 55% and 90%. Engagement goals for work and activity centers were 90%, and 50% to 80% respectively. It was good to see that engagement was being regularly measured and that individualized goals were established.

During the period from October 2016 through March 2017, established goals were not met for any of the individuals reviewed.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	487	557	530	482	293	428	8	444	51
22	For the individual, goal frequencies of community recreational activities are established and achieved.	44% 4/9	1/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

22. All of the individuals had goal frequencies for community recreational activities identified in their ISPs. Four of the individuals, Individual #487, Individual #557, Individual #530, and Individual #482, met or exceeded their goals from October 2016 through March 2017.

23. Based upon the evidence provided, none of the nine individuals had participated in training in the community.

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

Outcome 9 – Students receive educational services and these services are integrated into the ISP.	
Summary: Many of the sub-indicators were met, including action plans in the ISP to support the IEP. IDT review of progress is also required to meet criteria. This indicator will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	487	557							
25	The student receives educational services that are integrated with the ISP.	0% 0/2	0/1	0/1							

Comments:
25. Individual #487 and Individual #557 were both enrolled in school at the time of the visit. For both individuals, there was public school related information in their ISPs and there were action plans to support their IEPs. This was all very good to see.

On the other hand, there was no evidence for either student that his progress in school had been reviewed by the IDT. As Individual #557's IEP was from his previous school district, there was no evidence that his QIDP or other IDT member had participated in the IEP process.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.

Summary: N/A

Individuals:

#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									

Comments: 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 development of communication goals/objectives that are clinically relevant, and measurable is an area on which the Center needs to focus. These

Individuals:

indicators will remain under active oversight.											
#	Indicator	Overall Score	51	428	172	551	264	541	7	435	212
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The goal/objective that was clinically relevant, as well as measurable was Individual #7's goal/objective related to activating a switch to a single-message device. c. through e. For Individual #7, integrated data review was inconsistent and delayed. In the April 2016 Communication Update, the Speech Language Pathologist (SLP) recommended the goal, but in September 2016, Individual #7 was still waiting for the SLP to obtain the needed equipment. Integrated reviews included data for the month of October, but not for November. They included data again for December 2016 and January 2017. The Monitoring Team conducted a full review for this individual. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable 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	51	428	172	551	264	541	7	435	212
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
Comments: None.											

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "Overall Score."]			Individuals:								
#	Indicator	Overall Score	551	360	510	203	544	278	140	105	General Use Book - Home 6330
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	40% 4/10	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
			Individuals:								
#	Indicator		General Use Object Cue Mat - Home 6330								
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1								
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/1								
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/5									
Comments: a. and b. It was concerning that often individuals' AAC devices were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.											

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. This is only the second round of reviews in which the Monitoring Team reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, early in 2016, the Center began additional post-move monitoring responsibilities, and had begun 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.

Center staff had identified many supports for the two individuals reviewed, and it was positive IDTs had made a diligent effort to address their needs. However, more work was needed to make supports in the CLDPs measurable. In addition, 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 PMM was very diligent in following up to ensure corrective actions were implemented in a timely manner for the supports that were not being provided as needed. The Monitoring Team found this to be an area of strength in the Center's transition processes. Improving the measurability of supports is necessary to ensure that reliable and valid data can be used to measure whether or not supports are provided once the individual transitions to the community. These indicators will remain in active oversight.

One of the individuals experienced a PDCT event. The IDT had identified the risk prior to the move and developed a clear support to address it, but community provider staff did not follow the support.

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.

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: Center staff had identified many supports for the two individuals reviewed, and it was positive IDTs had made a diligent effort to address their needs. However, more work was needed to make supports in the CLDPs measurable. In addition, a number of essential supports were missing from the CLDPs reviewed,	Individuals:

and this should be a focus for Center staff. These indicators will remain in active oversight.											
#	Indicator	Overall Score	74	533							
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. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how needs and preferences should be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to adjust as needed. For these two CLDPs, supports were not yet consistently measurable.

The respective IDTs developed ten pre-move supports and 51 post-move supports for Individual #74 and eight pre-move supports and 44 post-move supports for Individual #533.

a. The ten pre-move supports for Individual #74 included completion of medical testing/appointments, delivery of information and documents to the provider, and several actions for the provider to take. The latter actions included providing a pill crusher at the home and day program to modify prescriptions prior to administration. This was measurable. Another support called for the provider to develop a schedule for the community that kept Individual #74's routine as close to his current one as possible. This was not clearly measurable.

b. The CLDP for Individual #74 did include three pre-move supports for training of specific provider staff, which was an improvement from the findings from the previous monitoring visit. While this was a positive development, the training supports lacked specific competency criteria. For example, a pre-move support called for nursing staff to provide competency-based training on Individual #74's medical/nursing needs and listed a set of topics to be covered, such as side effects to report to the nurse, bowel movement monitoring, and medical diagnoses and medications used to treat them. The support did not provide any details describing specifically what staff needed to know, nor did it call for any testing of staff knowledge. Instead, the IDT required a copy of the training materials, a signature sheet showing which staff were trained, and for the Post-Move Monitor (PMM) to be present at the training. The presence of the PMM, while helpful for ensuring her own knowledge for the purposes of accurate monitoring, would not serve to demonstrate provider staff knowledge or competence. Some of these supports had companion post-move supports that provided some additional information, such as a post move-support indicating staff would document bowel movements daily and to notify the nurse if he went two days without one. The PMM was responsible for checking this documentation at the time of the seven-day PMM visit, but it is essential that pre-move supports provide for confirming staff knowledge for important needs such as this prior to the move. If provider staff did not have this knowledge of the need to track and report his bowel movements, serious consequences could develop in the first seven days.

c. The CLDP for Individual #533 also included three pre-move supports calling for competency-based training, covering needs in the areas of medical/nursing, behavior, and habilitation.

- Like those described above for Individual #74, the pre-move support for medical/nursing did not have the needed

detail, listing broad topics without specific detail, competency criteria, or confirmation of staff competence. The other two pre-move training supports were more detailed about the content of the training, which was positive. For example, a support for habilitation training indicated this would cover his assistive eating equipment and listed each of the items, as well as where and when they should be used.

- While the habilitation and behavioral supports did show improvement, all the topics to be included did not provide that level of specificity about content and/or competency criteria. For example, the habilitation training support indicated it would include assistance needed with activities of daily living (ADLs), but did not specify what staff should know about the assistance he needed.
- As with Individual #74's pre-move training supports, these three required a copy of the training materials, a signature sheet showing which staff were trained and for the PMM to be present at the training, but no specific confirmation of staff knowledge prior to transition.

d. It was positive that many post-move supports for both Individual #74 and Individual #533 required interviews with staff as evidence they were knowledgeable of support needs in addition to observations and documentation. Some of these supports also provided specific criteria the PMM could use, such as supports for assistive eating equipment as well as for most mealtime techniques for Individual #74. For Individual #533, a positive example included the detail provided in his post-move support for mealtime techniques. Still, other supports did not consistently specify what the PMM needed to ask to confirm that staff were knowledgeable of these supports.

- For example, Individual #74's CLDP included several behavioral supports, but the support for his PBSP stated that provider staff would use preventative techniques "as trained."
- Individual #533 had a history of urinary retention. A support called for staff to prompt Individual #533 to use the restroom at least once per day, which would not be sufficient for anyone, even without this history. While this was technically measurable, it did not provide the PMM with the information needed to test staff knowledge about his needs in this area.

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. Neither CLDP comprehensively addressed support needs and did not meet criterion, as described below:

1. Past history, and recent and current behavioral and psychiatric problems: Supports did not sufficiently reflect the individuals' past history, and recent and current behavioral and psychiatric problems in a consistent manner. Examples included:
    - For Individual #74:
        - Per the Integrated Risk Rating Form (IRRF), Individual #74 engaged in behaviors, including aggression (pushing, punching, kicking, slapping, or shoving of others); property destruction (damaging or destroying property to include tearing down curtains, ripping clothes, hitting the TV/VCR case, throwing furniture or other objects); biting others (biting or attempting to bite other people); and self-injurious behavior (biting himself, slapping or hitting himself, or pulling his hair). The IRRF indicated target behaviors should be addressed with a combined treatment of positive behavior supports and psychiatry supports. It further noted that his long history of maladaptive behavior had required the coordination of both disciplines to provide the most effective treatment. The behavioral and psychiatric assessments also recommended an integrated treatment between psychology and psychiatry, but the CLDP did not include a related support.

- As described with regard to Indicator 1, the CLDP included many supports for behavioral needs, but the support for implementation of his behavior plan stated staff would use preventative techniques "as trained." It was notable that provider staff could not demonstrate a full understanding of the behavioral strategies at either the seven-day or 45-day PMM visit.
- Per the ISP, Individual #74 had a long history of refusing meals or engaging in challenging behavior when presented with a meal he did not enjoy. The CLDP did not include any support requiring staff knowledge of his food preferences.

- For Individual #533:
  - The behavior assessment indicated the PBSP included replacement behaviors of choosing a drink and engagement during outings. The CLDP stated the replacement behavior included asking for what he wanted by pointing to pictures and that current services included use of picture board as an aid for choosing activities and making drink choices. None of the CLDP supports included a specific reference to the picture board.
  - The psychiatry assessment reported Individual #533 was stabilized on the current dose of Zyprexa. It also indicated Risperdal had not been effective at a lower dose, but that a higher dose caused ataxia and led to increased falls. Further, it recommended if behavior deteriorated, a nurse, primary care practitioner (PCP), or behavior analyst should be consulted before making major changes to psychotropic medication regimen. It was positive the CLDP included a support for psychiatric care that specified the new psychiatrist would be given information on the recommendation not to change Zyprexa, but it did not include the other related concerns. In addition, the psychiatry assessment recommended follow-up with the community psychiatrist within four weeks of transition. The IDT concluded this recommendation could be modified to a timeframe of 90 days, stating further that his community PCP could monitor his Zyprexa until he was under the care of a psychiatrist. In this instance, it appeared that the IDT made a decision based on the convenience of the community provider as opposed to the clinical needs of the individual. Overriding the specific clinical recommendation of the psychiatrist required clear justification, which the team did not document in the CLDP (i.e., other than to say the individual was seen recently and was "stable"). Moreover, under these circumstances, it would have been important for the PCP to receive this same information regarding not changing the Zyprexa. The listing of recommendations for the PCP to review and monitor did not include this important information.

2. Safety, medical, healthcare, therapeutic, risk, and supervision needs:
   - For Individual #74, the CLDP included many supports related to his safety, medical, and healthcare needs. As described above, it was positive the IDT developed measurable post-move supports for his assistive eating equipment and mealtime techniques that provided essential details provider staff needed to be aware of to ensure his health and safety. Support needs that were not thoroughly addressed included, for example:
     - It was disappointing the IDT did not apply the same methodology for communication supports as it did with the mealtime supports. Individual #74's ISP provided an extensive description of his communication skills. It indicated he communicated primarily by single word approximations, gestures, and some simple signs. Signs and verbal approximations used included bathroom, thank you, please, Spock, and Hook. He could answer yes/no questions with verbal approximation of "yes" and "no." He would point to pictures to express his wants and needs with his communication book. It also noted he could be difficult to understand at times.

Receptively, he could understand simple questions as well as answer "what" and "who" questions. He could follow routine commands such as come here, sit down, go to your room, and time to eat, etc. It further noted he required gestural and/or picture cues to understand new and novel directions. A pre-move support for Habilitation Therapies competency-based training topics included signs/gestures used and the use of his communication book, but did not include any specifics on either topic. The speech assessment indicated staff should verbally prompt him to use his communication book in addition to speech during all interactions throughout the day and use signs/point to pictures that relate to ongoing activity or topic; and, to have him imitate staff speech/signs and point to pictures. The only post-move communication support stated provider staff were to ensure he had his communication book with him at all times. No competency criteria were provided and the only competency demonstration was for a signature sheet showing the staff trained.

- The CLDP focused some attention on his required supervision level in the community setting. It included a support for one-to-one supervision for Individual #74 during waking hours, but it also specified one-to-one was not required when he was calm in his bedroom watching television, drawing, or sleeping. This support did not include any strategy for staff to remain aware of whether he continued to be calm and/or asleep. The CLDP also included some additional environmental strategies to ensure his safety. These included replacing the windows in his room with plexi-glass prior to or within one week of transition. The need for this support was raised during a pre-placement visit, when Individual #74 broke a window in his bedroom and sustained injuries requiring medical attention. This occurred while provider staff was present in the room, so the issue did not seem to be confined to times when he was alone. This indicated a need for the one-to-one supervision to be more specific about whether the staff needed to be in a certain proximity. The CLDP also indicated a formal support for prompting with pedestrian safety skills was not needed because provider staff would do this as part of supervision, but the support for supervision did not specify this need or call for the PMM to monitor for specific staff knowledge.
- Individual #74 had moderate pharyngeal dysphagia and history of a serious choking event requiring the use of the Abdominal Thrust maneuver. He also had a history of enteral feeding and a recent history of surgery for a paralyzed left vocal cord. Per the Speech/Language Pathologist (SLP) assessment, nursing staff, the primary care physician (PCP), and the SLP needed to closely monitor him. The assessment also indicated if he presented with severe breathy/hoarse voice quality, unproductive coughs, and coughing during meals, this may be indicative that the vocal cord needed attention; therefore, he needed to be monitored for voice quality and coughing during meals. Pre-move training for habilitation therapies did include the need to report any coughing during meals to the nurse immediately, but did not address monitoring for voice quality. A post-move support for monitoring during meals also did not include vocal quality as a symptom for which staff needed to watch.
- CLDP supports did not clarify his needs for any mobility supports. Various assessments noted mobility needs. For example, both the nursing and habilitation therapies assessments noted he sometimes used a gait belt if unsteady. The latter assessment also stated he had an abnormal gait pattern with toes externally rotated and often shuffled. The Functional Skills Assessment (FSA) summary from 7/16, which was attached to the update, indicated he needed assistance with climbing stairs, and perhaps going up steep hills or using the escalator, and that at times he seemed unbalanced when walking or running. The CLDP did not include any

supports for staff knowledge related to these assessed needs.
    - Per assessments and the CLDP narrative, Individual #74 received allergy shots every two weeks and this had been effective in controlling his symptoms. The CLDP narrative indicated the ear, nose and throat (ENT) physician would monitor his allergy injections. The CLDP did not include a support related to his allergy injections. It did include a support for an appointment with an ENT to be scheduled by August 2017, to include monitoring for allergies, but this did not address how the allergy injections would be provided or monitored in the interim.
    - The CLDP did not specify any ongoing monitoring by nursing, OT/PT, or SLP.
        - Individual #74 had a long history of chronic ear infections. The CLDP included two related post-move supports The first called for provider staff to ensure he used a headband when he showered to avoid getting water in his ears. A second support required staff to monitor for any drainage from his ears and report to the nurse immediately if drainage was observed. No support called for the provider nurse to do any sort of periodic checks.
        - Per the SLP assessment, nursing staff, the PCP, and the SLP needed to closely monitor him. The CLDP did not call for any monitoring by nursing staff. A support did call for the provider SLP to contact the Center SLP within 90 days of transition, but did not require any ongoing monitoring. It was also unclear why this lapse of time would be appropriate to meet his needs.
- For Individual #533:
    - He had an extensive history of falls, including 17 falls within last year, per the medical assessment. Per the nursing assessment, Individual #533 had numerous injuries related to falls. The habilitation therapies assessment noted he had difficulties with stairs and uneven terrain, requiring verbal cues to slow down and watch where he is going. The nursing assessment also indicated the physical and nutritional management team (PNMT) was following him related to falls; he was to wear high top shoes and pants that fit appropriately; he had enhanced supervision when outside, and he was to receive assistance on uneven grounds. Other interventions included identification by behavioral services of falls precursors related to aggression and staff training to have more detailed documentation for falls. The CLDP addressed staff knowledge of the clothing requirements only.
    - As described above, the CLDP noted that current services included use of picture board as an aid for choosing activities and making drink choices. No support called for staff knowledge or use of a picture board.

3. What was important to the individual:
    - For Individual #74, the CLDP listed important personal preferences, including being closer to his family so he could see his mother more often, having his own room where he could watch his preferred movies and draw in his magazines, and having more independence to do things in the community and with his peers. His ISP indicated he enjoyed having weekly calls with his mother. While Individual #74 did have his own room, supports did not specify this. Supports did include staff assistance to call his mother once a week, but did not foster any opportunity to see her more often. The CLDP did not include supports for having more independence to do things in the community or with his peers.
    - For Individual #533, the CLDP identified important outcomes as maintaining contact with his sister, having a smaller home environment, getting more individualized attention from staff, and having more independence to access the community with support from staff. The CLDP did address maintaining contact with his sister, but did not address the

other two outcomes. For example, the CLDP included a support for Individual #533 to be provided with community outings at least once per week. Discharge assessments indicated he eagerly went on outings three to six times per month, so this support did not include an expectation for increased access. It also did not specify any strategies for increasing his independence when accessing the community.

4. Need/desire for employment, and/or other meaningful day activities in integrated community settings:
    - For Individual #74, the Center did not provide a vocational/day program assessment for review. The CLDP called for provider staff to ensure he had regular attendance at the day program during the week, and to redirect him to a sensory room or gym if he showed signs of being bothered by the noise level at the day program. Supports did not describe any meaningful activities he should be engaged in while at the day program or in any integrated community settings.
    - For Individual #533, the Center did not provide a vocational/day program assessment for review and supports did not describe any meaningful activities he should be engaged in while at the day program or in any integrated community settings.
5. Positive reinforcement, incentives, and/or other motivating components to an individual's success:
    - For Individual #74, the CLDP did include some supports for access to preferred items and activities. Also, as noted above, a support indicated he should be redirected to a sensory room or gym if he showed signs of being bothered by the noise level at the day program. Supports did not specifically address the replacement behaviors for waiting and engaging in training activities, both of which included elements of positive reinforcement. It was again notable that provider staff did not demonstrate knowledge of or competence for implementation of these replacement behaviors.
    - The CLDP for Individual #533 did include a specific support for provider staff to use giving alternative choices as outlined in his behavior support plan, which was positive. As described above, though, his CLDP indicated an important outcome for him was to have more individualized attention from staff, but did not include supports that focused on providing him with individualized attention.
6. Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs developed supports related to teaching, maintenance, participation, and acquisition of specific skills for each individual.
    - The CLDP for Individual #74 included supports to have skill training in place for making a call and for using the TV remote within one week of transition.
    - The CLDP for Individual #533 included two supports related to acquisition of specific skills, including using his communication book to communicate with staff and to continue training for pouring his own drink.
7. All recommendations from assessments are included, or if not, there is a rationale provided: Overall, the Center implemented a good process for reviewing CLDP assessments and for making and documenting team decisions about recommendations. Still, there were recommendations that were either not addressed or did not have an adequate rationale provided for not being included. Sometimes clinicians imbedded recommendations in their assessment narratives, but did not carry them through to the recommendations section. This resulted in important recommendations not being carried over to the CLDP discussion and or included in CLDP supports. Examples of recommendations not included without needed justification included:
    - Individual #74's psychiatry assessment indicated he should follow-up with the community psychiatrist within no later than four weeks of transition. It also included recommendations for monitoring for metabolic syndrome due to taking Zyprexa and for nursing to monitor for side effects of psychotropic medications every six months. The IDT support for psychiatric consultation indicated it would be completed within 90 days, even though both the behavioral and

psychiatric assessments indicated it was important to maintain current behavioral supports including integrated treatment between the BCBA and the psychiatrist.

- The habilitation therapies and behavioral assessments both indicated Individual #74 required padding around his bed to prevent injury during episodes of banging his head, but the CLDP did not include a related support. The narrative indicated this need was discussed, but that a larger bed would be purchased and did not need to be placed against a wall. The CLDP should have included a support that specified these accommodations would be made, rather than addressing it only in the narrative.
- As described above for Individual #533, the CLDP did not include all recommendations related to falls prevention.

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. The PMM was very diligent in following up to ensure corrective actions were implemented in a timely manner for the supports that were not being provided as needed. The Monitoring Team found this to be an area of strength in the Center's transition processes. Improving the measurability of supports is necessary to ensure that reliable and valid data can be used to measure whether or not supports are provided once the individual transitions to the community. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	74	533							
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 status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's assessment is correct based on the evidence.	100% 2/2	1/1	1/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	100% 2/2	1/1	1/1							
8	Every problem was followed through to resolution.	100% 2/2	1/1	1/1							
9	Based upon observation, the PMM did a thorough and complete job of post-	N/A	N/A	N/A							

	move monitoring.										
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	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. The Monitoring Team commended the PMM for the thoroughness and attention to detail found in this documentation.

4. In many cases, the PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports. As noted above, the PMM consistently provided comments that were complete and addressed the required evidence. Still, it was not always possible to ascertain whether reliable and valid data were present due to a lack of specificity and measurability of some supports as described with regard to Indicator #1. The Center can move toward compliance for this indicator by ensuring the CLDPs provide clearly measurable supports.

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. Both individuals had PMM visits shortly before the Monitoring Team's on-site reviewed and these reports were also reviewed once the documentation was finalized. The Monitoring Team found improvement, in that both individuals were receiving supports as required on a more consistent basis, but both also continued to have some supports identified as unmet.

- Individual #74 did not consistently receive supports as listed and/or described in the CLDP. Examples included:
  - At the time of the seven-day PMM visit:
    - Provider staff at both the day program and the home were not knowledgeable regarding all his medical/nursing, behavioral, and habilitation supports and required re-training by the PMM or, in the case of behavioral supports, by the Center's BCBA.
    - The bowel movement tracking log was not in place at either the home or day program.
    - Provider staff had not documented assistance with tooth brushing on the MARs as required.
    - Individual #74 was not receiving the correct diet texture. Staff provided him with ground instead of chopped, which he did not like. Provider staff were not aware of the correct technique for using the freezer cup to prepare his thickened liquids.
    - Individual #74 did not receive prune mash as required.
    - Provider staff could not locate Individual #74's communication book.
    - Staff did not have knowledge of how to implement the replacement behaviors in Individual #74's PBSP or how to use the data sheets to record.
  - At the time of the 45-day PMM visit:
    - Provider staff still could not implement behavioral techniques as required, nor was documentation consistently available. Individual #74 continued to experience behavioral issues, including self-injurious behaviors that had resulted in some injury, such as scratches and bleeding from bites, so this was a significant concern.
    - The PMM noted documentation for tooth brushing was still missing, as was documentation Individual #74 received prune juice as required.

- His plate guard was not available because it had been broken, but had not yet been re-ordered. The PMM comments did not make clear how long the plate guard had been unavailable.
- Provider staff had not implemented his two skill acquisition programs.

- Individual #533 was not consistently receiving supports as listed and/or described in the CLDP, although not to the extent evidenced for Individual #74. Examples of supports not received included:
  - The provider had not received four of Individual #74's over-the-counter prescribed medications when he transitioned. On the day of transition, the provider staff listed on the MAR the medications sent by the Center. No one identified the four medications were missing.
  - Provider staff had not recorded assisting Individual #533 to brush his gums daily, but the PMM did document that staff interview appeared to indicate the support had been provided. Under the circumstances, the PMM still appropriately scored the support as not in place.
  - Provider staff had not implemented his two skill acquisition programs.

6. Overall, the Post-Move Monitor's scoring was correct, based on the supports defined in the CLDP.

7. and 8. The PMM was very diligent in following up to ensure corrective actions were implemented in a timely manner for the many supports that were not being provided as needed for Individual #74. It was positive the IDT met to review the PMM Checklists and make recommendations for any unmet supports. The PMM also documented that needed follow-up had been completed for Individual #533. The Monitoring Team found this to be an area of strength in the Center's transition processes.

9. and 10. During the week of the onsite review, no local post-move monitoring visits were scheduled.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.

Summary: One of the individuals experienced a PDCT event. The IDT had identified the risk prior to the move and developed a clear support to address it, but community provider staff did not follow the support.			Individuals:								
#	Indicator	Overall Score	74	533							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1							

Comments: 9. Individual #533 experienced a PDCT event during the first 90 days after transition. The IDT had identified the risk prior to the move and developed a clear support to address it.

- He required a visit to the emergency room for stitches to his finger after having the door close on his hand. This occurred as staff

readied to take individuals living in the home on separate outings and told another individual scheduled for a different activity it was time to leave, while Individual #533 was waiting for his trip to begin. He attempted to go out both the back and front doors. Staff tried to re-direct him unsuccessfully and then closed the front door. Individual #533 reached out and tried to stop them by putting his hand in the door. As he pulled it back out, he sustained a laceration and soft tissue damage. He was treated at the ER, requiring to stitches.

- The IDT met and determined the event was preventable, if the provider staff followed the instructions of the support and included in pre-move training. The CLDP identified attempting to leave the home as a known risk and included a support that called for a second staff person to be on call from the provider home next door. In the event of Individual #533 leaving the home, instructions called for staff to try to re-direct. If unsuccessful, he should be allowed to leave with one of the two staff to accompany him. This support clearly spelled out the requirements. During PMM visits prior to the PDCT, the PMM documented verifying provider staff knowledge about this support.
- In discussing whether anything could have been done differently, the IDT focused on the incorrect responses of the provider staff and the re-training the provider completed. It was positive the provider had taken this action promptly, per the ISPA documentation.

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. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	74	533							
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.	50% 1/2	0/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g.,	0%	0/1	0/1							

	PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0/2									
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	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.	50% 1/2	0/1	1/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	0% 0/2	0/1	0/1							
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 updated the IRRF for Individual #533, whose CLDP was more recent, but not for Individual #74. It was positive the Center had begun undertaking this review as a consistent practice. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process, as it typically contains a great amount of information. Examples of assessments that were not updated as needed included:
  - For Individual #74, the Center did not provide an updated vocational/day, vision, or pharmacy assessment.
  - For Individual #533, the Center did not provide an updated vocational/day, vision, audiological, or pharmacy assessment.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments that were not available or updated had a negative impact on the scoring of this indicator for both individuals. In addition:
  - For both Individual #74 and Individual #533, the FSA update was very limited in scope and content.
  - The communication update for Individual #533 was also brief and limited in scope.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not consistently meet criterion for this indicator. Again, missing assessments factored into this determination. Other issues included:
  - For Individual #74, the FSA update recommendations were again very limited in scope and content. For example, Individual #74's update indicated potential skill deficits identified for further training included, very broadly, behaviors and communication. The assessment did not state any specific needs in either of these areas.
  - Likewise, for Individual #533, the potential skill deficits identified for future training were broadly stated as communication and short attention span, with no specific needs or recommendations in either of these areas.
- Assessments specifically address/focus on the new community home and day/work settings: Some assessments provided recommendations that focused on community needs. A good example was the social assessment for Individual #74. For Individual #533, the FSA update did include some specific supports for community transition, including having staff with him to cross the street due to declining skills in this area. Some other assessments did not reflect they had been updated to focus on community needs. For example, the behavioral assessment for Individual #533 included recommendations that alluded to Center-specific activities.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) and 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. The CLDP for Individual #533 met criterion. For Individual #74, the Transition Logs indicated the LAR was often involved and consulted in the transition process, but it was concerning the Center arranged for an overnight provider visit without consulting the LAR. The LAR expressed her displeasure about this activity and the Center did respond appropriately by ensuring it did not happen again.

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: As described above under Indicator 1, both CLDPs included pre-move training supports. These supports did identify staff to be trained and in some cases provided specific detail about the content of the training. None of the pre-move training supports indicated how provider staff competence would be measured. The Monitoring Team requested and reviewed training documentation. This included both the training and testing materials. It was positive Individual #74's training materials included much specific detail beyond what was stated in the supports themselves. It was also positive that testing materials for Individual #533 included knowledge of medication side effects. Otherwise, the tests for both individuals were limited in scope and did not address many of their individual needs. For example:

- Individual #74 had many very specific mealtime techniques. While this information was included in the training, the testing consisted of only four questions. Only two of the four required provider staff to demonstrate knowledge of the specific techniques. Individual #74 also had many specific communication needs, but the testing reviewed did not address these.
- The Monitoring Team did note that the Pre-Move Site Review (PMSR) for Individual #74 documented the PMM observed additional competency demonstration that was not specified in the training supports or otherwise documented. For example, the PMM documented she observed provider staff at the home and day program demonstrate how to thicken liquids to honey consistency. It was positive the Center included this competency demonstration and the IDT should describe this type of requirement in the pre-move training supports as well as document the competency demonstration results for each staff person trained.
- The test for Individual #533's integrated health care plan instructions for direct support staff had one item for risks related to osteoporosis/falls/fractures. It asked staff to answer a multiple-choice question about the appropriate action to take if he were to sustain a fracture. It did not pose any questions to test staff knowledge for falls prevention.
- The Center should also ensure that training is specific to community needs. Some training materials reference Center-specific instructions. For example, the habilitation testing asked why Individual #74 was on the Red Dot system, which was not used in the community setting.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The CLDP should provide a specific statement documenting its consideration of the need for any such collaboration, and a develop a corresponding support as appropriate.

- It was positive the IDT for Individual #74 included a support for the provider and Center BCBAs to discuss his progress within 14 days of transition and that the Center BCBA would accompany the PMM on both the seven-day and 45-day monitoring visits.

A support also called for the provider SLP to contact the Center SLP within 90 days to discuss information related to his vocal paralysis. While it was positive the IDT considered the need for this collaboration, it did not provide a clear rationale for waiting 90 days to ensure the provider clinician had this important information. To meet criterion, the CLDP needed to ensure collaboration was timely based on the individual's needs.

- The CLDP for Individual #533 did not include a specific statement about the need for collaboration. In at least two instances, the content of the CLDP indicated needs for collaboration that should have been specifically discussed. These included information that needed to be provided to community clinicians for cardiology and psychiatry.

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. The CLDPs did not document a statement regarding the need for any setting assessment and did not meet criterion.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs.

- Individual #74's CLDP did not provide a specific statement.
- The CLDP for Individual #533 met criterion. It documented that direct support staff accompanied him on a day visit to the provider location on one occasion and stayed near the home when Individual #533 completed his overnight visit.

18. The current LIDDA participated in both CLDPs, but the receiving LIDDA did not. The Center took additional steps to ensure the receiving LIDDA was informed, but CLDP participation by the LIDDA is crucial for ensuring the agreements to provide supports are clearly understood and documented. It was positive the LIDDA Enhanced Community Coordinator was present for the pre-move training for Individual #74.

19. The Pre-Move Site Reviews (PMSRs) for both individuals were completed in a timely manner and each indicated all supports were in place prior to the transition. Due to the lack of supports for staff training, knowledge and competence, the PMSRs for both individuals failed to document that provider staff had knowledge of important health and safety needs that should have been clearly in place at the time of transition. It was also concerning the Continuity of Care form the LIDDA completed for Individual #533 was signed and dated, but none of the boxes were checked to confirm the results of the review.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: This indicator will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	74	533								
	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	50% 1/2	1/1	0/1								
Comments: 20. Individual #74 was referred on 8/4/15 and transitioned on 3/1/17. Individual #533 was referred on 3/29/16 and												

transitioned on 4/6/17. Neither transition occurred within 180 days of referral.

- The Transition Logs documented regular and ongoing activity by the Center for Individual #74, including numerous community exploration activities as well as multiple pre-placement visits at the request of the LAR.
- For Individual #533, the Transition Logs also indicated ongoing activity, but did not clarify why there were often gaps of a month or more between these activities. For example, Individual #533 visited a provider on 8/18/16. It went well and the IDT agreed to an overnight visit on 9/15/16. After that visit, which also went well, the team agreed to set up another visit in late October or beginning of November. This visit took place on 10/28/16. The IDT did not indicate why there needed to be a month between visits; however, transition staff acknowledged it had many transitions in process which may have impacted the overall schedule.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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