United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

Dates of Onsite Review: February 26, 2018 to March 2, 2018

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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

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Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

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.

Overall, the Monitoring Team's review identified a number of concerns with some very basic issues related to dignity and respect, as well as the provision of treatment to address behavioral and healthcare issues. For example:

- Many individuals the Monitoring Team reviewed did not have schedules that included out-of-the-home activities on a daily basis. One of the individuals spent most of his day without clothes on under a sheet or blanket in his living room. Other individuals in the same home spent most of their time curled up on a couch or outside stooped down licking the door jam or lying on the ground. Many of these same individuals shared four-person bedrooms with poor quality mattresses, and the home had an unpleasant odor. Another individual, whom the Monitoring Team has reviewed a number of times in the past, still spends most of his day outside of his home pouring dirt on his head and shoulders.
- The Monitoring Teams' numerous observations in the young boys' home showed a lack of engagement, and staff playing more of an observation role than an active engagement role.
- Staff working with individuals with co-existing mental health concerns and intellectual disabilities appeared to lack basic understanding of the mental health diagnoses, and made statements to individuals that were, at times, counter-therapeutic. Staff seemed not to understand their role in assisting such individuals to build self-esteem.
- For individuals with complex needs, clinicians and Qualified Intellectual Disabilities Professionals (QIDPs) often stated that "individuals had come a long way" and then dismissed ideas about how to improve the substandard treatment currently provided.

As a field, we currently have the knowledge and treatments that would improve the lives of many of these individuals. Although since the last review, Abilene SSLC made progress in some important areas, it is of utmost importance that staff make changes to improve the day-to-day lives of many of the individuals served. To accomplish this, staff first need to believe that they can make a difference, and that with the right assessments, plans, and implementation of those plans, rapid improvement for individuals can occur. Entire IDTs, but particularly, Behavioral Health Services as well as the Psychiatry Department will need to work closely together to address many of the concerns the Monitoring Team identified. Residential as well as Active Treatment staff also need to play a key role in making needed changes.

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. Thirteen of these indicators were moved to, or were already in, the category of less oversight after the last review. Presently, six additional indicators will move to the category of less oversight. These indicators are in the areas of restraint, and incident management. This results in the entirety of Outcome #15 related to restraint, and Outcome #3 and Outcome #4 related to incident management moving to the category of less oversight.

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

Overall, there was low usage of crisis intervention restraint at Abilene SSLC. The average duration of a physical restraint was also low, at less than two minutes. Crisis intervention restraint continued to be implemented and documented correctly. For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted. Attention to implementation, documentation, and review of non-chemical, pretreatment sedation, and general anesthesia for medical and dental procedures, however, is needed.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: completing timely monitoring of individuals who are restrained; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and completing physical assessments to check for injuries, and documenting the results.

Abuse, Neglect, and Incident Management

A number of problematic areas at the last Abilene SSLC review had since received attention and were corrected. For instance, the investigation review process was greatly improved. Abilene SSLC's review process was strong, regularly implemented, and it found many of the same issues the Monitoring Team identified. For example, although there were reporting problems with three of the incidents, the Center self-identified two of them. The third was a DFPS reporting delay. Abilene SSLC showed it was aware

of reporting issues and understood the importance of correct reporting. During interviews, staff who regularly worked with the individual correctly answered questions about ANE and incident reporting.

A number of DFPS investigations did not include interview of all relevant staff.

An area for focus for the incident management department is peer-to-peer aggression. Reportedly, staff intervened in most incidents, so injuries from peer-to-peer aggression were low, however, IDTs were not looking at ways to reduce incidents beyond ensuring behavior coaches were present and PBSPs were in place (though these too were important). Factors that might contribute to a high number of incidents in the homes included the lack of meaningful engagement, the absence of communication supports and opportunities to develop new communication strategies, and crowded/chaotic living environments.

Other

Given that the Monitoring Team identified unreported potential adverse drug reactions (ADRs), the Center did not appear to have a system to ensure that potential ADRs were reported immediately, further investigated, and probability scales completed.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: Overall, there was low usage of crisis intervention restraint at Abilene SSLC. The average duration of a physical restraint was also low, at less than two minutes. Attention to review of non-chemical, pretreatment sedation, and general anesthesia for medical and dental procedures is needed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	100% 12/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	80% 8/10	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 1. Twelve sets of monthly data provided by the facility for the past nine months (May 2017 through January 2018) were reviewed. Overall, the census-adjusted frequency of occurrence of crisis intervention restraint was on a decreasing trend over the nine-month period, was about the same (low) as at the time of the last review, and was now the fourth lowest in the state. The frequency of crisis intervention physical restraint followed the same pattern because all but two 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 remained the second lowest in the state, now at under two minutes. The frequency of crisis intervention chemical restraints was two, with none since July 2017, and there was infrequent, somewhat specialized use, of mechanical restraint (wristlets) for one individual.

No individuals had protective mechanical restraint for self-injurious behavior (PMR-SIB) and about the same number of individuals had crisis intervention restraint each month as at the time of the last review (about six). Few injuries were reported to have occurred during restraint and those were deemed non-serious (though see comments below regarding nurse documentation, or lack of documentation, of restraint injuries, under restraint indicator (b)).

There was a low number of individuals for whom there was usage of non-chemical restraints for medical and dental procedures (though one individual had frequent usage, Individual #93). Similarly, the pretreatment sedation was used for few individuals. The usage of general anesthesia (Abilene SSLC did not use TIVA) remained at about 50 individuals per year.

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

Restraint reduction committee was active, meeting each month. Overall restraint usage was presented at the meetings. The Monitoring Team recommends that all 12 sets of data in this indicator be incorporated into restraint reduction committee review. At this point, data regarding non-chemical restraint, pretreatment sedation, and TIVA/general anesthesia were not being reviewed by the committee. Interestingly, the committee did review peer-to-peer aggression data.

2. Five of the individuals selected for review by the Monitoring Team were subject to restraint. The Monitoring Team also reviewed a medical restraint for one additional individual. Of these six individuals, three received crisis intervention physical restraints (Individual #423, Individual #474, Individual #561), one received crisis intervention mechanical restraint (Individual #199), and two received medical restraint (Individual #154, Individual #484). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for all but two individuals (Individual #199, Individual #423). The other five individuals selected by the Monitoring Team had no restraints making a total of eight of the 10 individuals meeting the criteria for this indicator.

<table>
<tr><td colspan="2">Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.</td></tr>
<tr><td>Summary: Crisis intervention restraint continued to be implemented and documented correctly. For instance, sustained high performance was shown for indicators 5 and 10 and, therefore, both will be moved to the category of requiring less oversight. With sustained high performance, indicator 11 might also be moved to this category after the next review. On the other hand, attention needs to be paid to the management and documentation of medical restraints. Thus, indicators 7 and</td><td>Individuals:</td></tr>
</table>

8 will remain in active monitoring. Not all supports were in place to have reduced the likelihood of crisis intervention restraint for two individuals, thus, indicator 9 will also remain in active monitoring.

#	Indicator	Overall Score	199	423	561	474	154	484			
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% 7/7	1/1	2/2	2/2	2/2	N/A	N/A			
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.	89% 8/9	1/1	2/2	2/2	2/2	0/1	1/1			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	89% 8/9	1/1	2/2	2/2	2/2	0/1	1/1			
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/2	0/1	0/1	Not rated	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	2/2	2/2	2/2	N/A	N/A			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for six different individuals (Individual #199, Individual #423, Individual #561, Individual #474, Individual #154, Individual #484). Of these, six were crisis intervention physical restraints, one was a crisis intervention mechanical restraint, and two were medical restraints. 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.

7-8. There was no documentation available for the medical restraint used for Individual #154. Therefore, these indicators were scored 0.

9. Because criterion for indicator #2 was met for four of the individuals, this indicator was not scored for them. For Individual #199 and Individual #423, criteria for this indicator were not met because their behavioral health assessments were not completed timely, there were some problems with implementation of PBSPs, and there was a need for better engagement in activities for both individuals.

Some factors that should be considered in trying to reduce restraint use include the lack of engagement and meaningful day

programming, the lack of choice and control that individuals have throughout their day, the lack of communication supports and opportunity to build communication skills, and living in a chaotic, noisy environment.

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

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: The restraint monitor arrived within the required timeframe for most, but not all restraints. The Center should continue to work on this. There was improvement compared with the last two reviews. Better documentation of medical restraint usage is required. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	199	423	561	474	154	484			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	71% 5/7	1/1	1/2	2/2	1/2	N/A	N/A			
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.	50% 1/2	N/A	N/A	N/A	N/A	0/1	1/1			
	Comments: 13. The restraint monitors arrived later than 15 minutes after initiation of restraint for Individual #423 1/5/18 and Individual #474 2/20/18, that is, 36 and 19 minutes, respectively. 14. Documentation provided for Individual #484 showed that the requirements were met. For Individual #154, there was no documentation available for his medical restraint usage.										

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.												
Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: completing timely monitoring of individuals who are restrained; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and completing and documenting physical assessments to check for injuries, and documenting the results. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	199	423	474	561	154	484				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	33% 3/9	1/1	0/2	1/2	1/2	0/1	0/1				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	33% 3/9	1/1	1/2	0/2	1/2	0/1	0/1				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	33% 3/9	1/1	1/2	0/2	0/1	0/1	0/1				

Comments: The crisis intervention restraints reviewed included those for: Individual #199 on 11/12/17 at 2:49 p.m. (mechanical: wristlets); Individual #423 on 12/21/17 at 3:45 p.m., and 1/5/18 at 10:25 a.m.; Individual #474 on 8/20/17 at 5:10 p.m., and 12/20/17 at 8:10 p.m.; Individual #561 on 10/20/17 at 4:24 p.m., and 12/27/17 at 8:30 a.m.; Individual #154 on 11/24/17 at 3:15 p.m. (wristlets to prevent removal of staples to right eyebrow); and Individual #484 from 10/2/17 to 10/8/17 (wristlets).

a. through c. For two of the restraints, nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individual. These were the restraints for Individual #199 on 11/12/17 at 2:49 p.m. (mechanical: wristlets), and Individual #561 on 10/20/17 at 4:24 p.m.

The following provide examples of problems noted:

- Nursing staff often did not initiate monitoring at least every 30 minutes from the initiation of the restraint. Those restraints for which this was not found included: Individual #423 on 1/5/18 at 10:25 a.m.; Individual #474 on 8/20/17 at 5:10 p.m., Individual #561 on 12/27/17 at 8:30 a.m.; Individual #154 on 11/24/17 at 3:15 p.m. (wristlets to prevent removal of staples to right eyebrow); and Individual #484 from 10/2/17 to 10/8/17 (wristlets).
- Vital signs were missing for some restraints. For example:
  - For Individual #423 on 1/5/18 at 10:25 a.m., no vital signs were found in the documentation provided;
  - For Individual #474 on 8/20/17 at 5:10 p.m., the nurse did not take the individual's vital signs until 6:01 p.m., at which time the individual's blood pressure (130/90) and pulse (118) were elevated, but the nurse did not re-take them.
  - For Individual #154 on 11/24/17 at 3:15 p.m. (wristlets to prevent removal of staples to right eyebrow), the Center indicated: "restraint checklist not found."
  - For Individual #184, restraint checklists, from 9/30/17 through 10/10/17, did not include daily vital signs.

- Some examples of problems noted with regard to the documentation of individuals' mental status included:
  - For Individual #423 on 12/21/17 at 3:45 p.m., an IPN, dated 12/21/17 at 3:50 p.m., indicated that "DSP [direct support professional] report still unsafe to interact with [Individual #423]." However, the LVN documented "no s/s [signs and symptoms] of distress noted, no change in mental status," which did not reflect that that Individual #423 was unsafe. Additional information was needed to clearly describe why she was considered unsafe at that time.
  - For Individual #423, an IPN, dated 1/5/18 at 11:33 a.m., only noted: "appears alert and oriented, talking with staff."
  - As noted above, for Individual #154, the Center indicated: "restraint checklist not found."
  - For Individual #184, restraint checklists, from 9/30/17 through 10/10/17, did not include daily descriptions of mental status.
- With regard to documentation of restraint related injuries:
  - For some restraints reviewed, nursing IPNs made no mention of the presence or absence of restraint-related injuries, and did not include documentation of a physical assessment (e.g., Individual #474 on 8/20/17 at 5:10 p.m., and 12/20/17 at 8:10 p.m.; and Individual #561 on 12/27/17 at 8:30 a.m.).
  - For Individual #474 on 12/20/17 at 8:10 p.m., nursing staff noted injuries, but did not provide information about whether they were related to the restraint, or, if this was unknown, stating so.
- For Individual #474's restraint on 8/20/17 at 5:10 p.m., the nursing IPN noted that the "resident requested prn [pro re nata, or "as needed"] Zyprexa 20 mg [milligrams] for agitation" and the "request approved by PCP on call." Given that PRN psychotropic medications are not allowed, it was unclear why an individual would be asking for one. In addition, the IPN stated that he was "calm," and from the documentation provided, it was unclear if the Zyprexa was administered, at what time, by whom, the rationale, and whether it was effective.
- Similarly, for Individual #474's restraint on 12/20/17, an IPN, dated 12/20/17 at 11:07 p.m., indicated that Olanzapine 10 mg by mouth (PO) was administered per the individual's request for agitation/anxiety. The nurse's IPN indicated that then the "[Behavioral Health Services staff] was contacted by telephone and he verbalized that is was appropriate to admin. aforementioned medications. [An MD was] contacted by telephone immediately and informed of [the BHS staff's] confirmation of appropriateness of use of aforementioned medication. [The MD] gave telephone orders to admin. Olanzapine 10 mg x 1 for agitation/anxiety per resident's request. Therefore, this medication was admin. immediately." However, it was not clear from the nurse's IPN whether the nurse administered the "PRN" after the individual requested it and before the nurse called the physician to obtain an order for it. Even if the additional medication was part of a written plan, it would still require a PCP order prior to administration. Again, given that PRN psychotropic medications are not allowed, it was unclear why an individual would be asking for one. No documentation was provided addressing the effectiveness of the medication. Also, on 1/30/18, a late entry was made noting that "an attempt was made to restrain [Individual #474] using a bear hug." It was unclear if a physical restraint actually occurred. Center staff documented: "No physician order available for the restraint due to miscommunication for need for order for attempted restraint."
- Additional concerns with regard to Individual #154's restraint included:
  - It was not clear why staples were used to close a facial wound.
  - It appeared a physical hold was used during the procedure, and afterwards, wristlets were used to prevent the individual from pulling out the staples. However, as noted above, the documentation indicated: "restraint checklist not found."
  - The documentation provided did not indicate how long the wristlets were used, when they were removed, if

circulation checks were conducted, what assistance was provided (i.e. meals, toileting, activities, etc.), and/or when they were discontinued.
- The Restraint Checklists for Individual #484, dated 9/30/17 through 10/10/17, indicated the individual was checked every 30 minutes. However, none of the restraint checklists indicated that fluids or food were offered. PCP orders were not in alignment with the dates on all the Restraint Checklists. In addition, the IPNs provided indicated that wristlets were being used from 9/18/17 through 10/22/17. Restraint Checklists were not provided for 10/11/17. Because of these inconsistencies, it was not possible to determine exactly how long wrist restraints were used on this individual.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: Abilene SSLC correctly documented crisis intervention restraints, but not medical restraints. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	199	423	561	474	154	484				
15	Restraint was documented in compliance with Appendix A.	78% 7/9	1/1	2/2	2/2	2/2	0/1	0/1				

Comments:
15. There was no documentation for the medical restraint for Individual #154. For Individual #484, the medical restraint checklists were, for the most part, incomplete (e.g., not showing date/time of release) or confusing (e.g., indicating location simultaneously in home and infirmary, indicating for pretreatment sedation). Some documentation was for multiple days and some had overlapping dates.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: Reviews of crisis intervention restraint had improved, resulting in 100% performance for the first time for indicator 16. As noted below, actions were taken, even though individuals already had CIPs. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	199	423	561	474	154	484				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 7/7	1/1	2/2	2/2	2/2	N/A	N/A				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A				

Comments:
17. While follow-up actions for each specific restraint were not required because each of these individuals had a crisis intervention plan, in each case specific follow-up occurred anyway. Usually, some type of review and revision of PBSPs and/or additional staff training occurred.

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: Consultation and review occurred for this individual and for individuals during the previous two reviews, too. Therefore, indicator 47 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	561								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								
48	Multiple medications were not used during chemical restraint.	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 #561 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 good performance on this indicator, with three of the four facility-only investigations meeting criteria. An area for focus for the incident management department (also see outcome 10, indicators 19-23) is peer-to-peer aggression. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	199	423	561	154	474	248	300		
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	92% 11/12	1/1	2/2	1/1	2/2	2/2	1/2	2/2		

Comments:
The Monitoring Team reviewed 12 investigations that occurred for seven individuals. Of these 12 investigations, eight were DFPS investigations of abuse-neglect allegations (three confirmed, three unconfirmed, two inconclusive). The other four were for facility investigations of serious injuries (fracture, laceration), a suicidal behavior, 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 #199, UIR 16678, DFPS 45549656, confirmed allegation of neglect, 9/18/17
- Individual #423, UIR 17411, DFPS 45608995, unconfirmed allegation of neglect, 10/1/17

- Individual #423, UIR 14187, DFPS 45378399, inconclusive allegation of physical abuse, 7/17/17
- Individual #561, UIR 17572, DFPS 45620808, confirmed allegation of verbal/emotional abuse, 10/11/17
- Individual #154, UIR 15519, DFPS 45426988, unconfirmed neglect and verbal/emotional abuse allegation, 8/18/17 (inconclusive findings changed to unconfirmed after Center appeal)
- Individual #154, UIR 17148, witnessed injury, laceration, head, 9/30/17
- Individual #474, UIR 19402, DFPS 45921447, unconfirmed allegation of physical abuse and verbal/emotional abuse, 12/1/17
- Individual #474, UIR 16535, suicidal action, date unknown
- Individual #248, UIR 20165, DFPS 46059088, inconclusive allegation of physical abuse and neglect, 12/21/17
- Individual #248, UIR 20644, unauthorized departure, date unknown
- Individual #300, UIR 15924, DFPS 45453128, confirmed allegation of neglect, 8/29/17
- Individual #300, UIR 17643, discovered injury, fracture, spine, 10/12/17

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

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 #248 UIR 20644, lack of correctly implementing his PBSP was 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.

An area for focus for Abilene SSLC is peer-to-peer aggression. There were about 150 occurrences of peer-to-peer aggression each month. Of these, about 12-15 per month caused a non-serious injury, such as a scratch or redness. There were, however, no occurrences of a serious injury to an individual from the aggression of another individual, which was good to see (and due at least in part to staff intervening quickly). That being said, the Center was not developing action plans to address the high incidence of peer-to-peer aggression unless an injury occurred. There was little documented discussion from IDTs regarding peer-to-peer aggression for individuals, although many were involved in numerous incidents as either the aggressor or victim. Factors that might contribute to a high number of incidents in the homes included the lack of meaningful engagement, the absence of communication supports and opportunities to develop new communication strategies, and crowded/chaotic living environments.

Another area is regarding inconclusive findings in DFPS investigations. The Center reported that this occurred when there were solely two witnesses and not enough evidence to make a firm determination. The frequency of inconclusive findings may or may not be a recurrent issue, but is worthy of IMC attention.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.												
Summary: Although there were reporting problems with three of the incidents, the Center self-identified two of them. The third was a DFPS reporting delay. Thus, Abilene SSLC showed it was aware of reporting issues and understood the importance of correct reporting. Performance maintained at about the same level as at the time of the last review. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	199	423	561	154	474	248	300		
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	75% 9/12	0/1	1/2	1/1	1/2	2/2	2/2	2/2		

Comments:
2. The Monitoring Team rated nine of the investigations as being reported correctly. The other three 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 #199 UIR 16678: The allegation was reported to DFPS by the individual. DFPS reported that it received the allegation at 6:47 am, but did not report it to the Center until 7:54 am, slightly more than one hour later.
- For Individual #423 UIR 17411: The incident occurred on 10/1/17 and was reported on 10/9/17. The Center identified and acknowledged this as a late report in the IMC review. It was good to see the review process identifying this.
- For Individual #154 UIR 17148: This injury was reported the subsequent day after being coded as a serious injury. The Center identified and acknowledged that it should have been reported shortly after staff knew he had sutures to close the wound. This self-identification was also good to see.

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: High performance was sustained for both indicators. Therefore, indicators 3 and 4 will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	199	423	561	154	474	248	300		
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 3/3	Not rated	Not rated	Not rated	Not rated	1/1	1/1	1/1		
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		

	reporting.										
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
	Comments:										

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
Summary: Abilene SSLC improved since the last review in clearly documenting the re-assignment of alleged perpetrators. Given a sustained high level of performance over this and the past three reviews (i.e., criteria met for 41 of 44 investigations), indicator 6 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	199	423	561	154	474	248	300		
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	92% 11/12	1/1	2/2	1/1	2/2	2/2	2/2	1/2		
	Comments: 6. For Individual #300 UIR 17643, the injury was due to a fall related to balance. There was no subsequent assessment of her status, ability, and need.										

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: A number of DFPS investigations did not include interview of all relevant staff. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	199	423	561	154	474	248	300		
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 12/12	1/1	2/2	1/1	2/2	2/2	2/2	2/2		
9	Relevant evidence was collected (e.g., physical, demonstrative,	67%	1/1	1/2	1/1	1/2	1/2	1/2	2/2		

	documentary, and testimonial), weighed, analyzed, and reconciled.	8/12									
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)	75% 9/12	1/1	2/2	1/1	1/2	1/2	1/2	2/2		

Comments:
9-10. A number of DFPS investigations did not interview all of the relevant staff. This was identified by the IMC as part of the Center's review process. The IMC reported that when she finds that a staff was not interviewed, she contacts DFPS to tell them, and she notes it in the UIR.

Timely and inclusive interview of all people relevant to the case is a very important part of conducting a quality investigation. This should be addressed by DFPS.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: A strength of any incident management program, and certainly at Abilene SSLC, is the investigation review process. Abilene SSLC's was strong, regularly implemented, and it found many of the same issues identified by the Monitoring Team. This was very good to see and resulted in a 100% scoring for indicator 13. Two DFPS investigations were not completed in the required timeframe. This indicator (12) will remain in the category of less oversight, but this should be addressed in order for it to remain in this category. Indicator 13 will remain in active monitoring, but with sustained high performance might be moved to the category of requiring less oversight after the next review.

Individuals:

#	Indicator	Overall Score	199	423	561	154	474	248	300		
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.	100% 12/12	1/1	2/2	1/1	2/2	2/2	2/2	2/2		

Comments:
12. Two investigations were not completed in the required timeframes. Both had extension requests, however, even so, initial interviews of relevant staff did not begin until day 10 and day 16 for Individual #423 UIR 17411 and Individual #248 UIR 20165,

respectively.

13. IMC review section of the UIRs was very thorough, touching on, for the most part, all relevant considerations in a series of summary statements. This was a good improvement since the last review. It showed a review of the investigation procedures as well as the investigation's conclusions. For the DFPS investigations of allegations, the IMC review provided an independent analysis and made independent conclusions; it did not merely re-state DFPS' findings and conclusions.

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 attended to, and improved, the non-serious injury investigation process to 100% from 38% at the time of the last review. This was good to see. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 199	423	561	154	474	248	300		
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.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		

Comments:

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

Summary: Overall, there was good performance for all three indicators. Criteria were met for all investigations for all individuals with two exceptions. One was a documentation error in the UIR. The other was more serious, that is, an absence of disciplinary action for fraudulent documentation of room checks by direct support professional staff. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 199	423	561	154	474	248	300		
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	90% 9/10	1/1	1/1	0/1	2/2	1/1	2/2	2/2		
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	88% 7/8	0/1	1/1	1/1	2/2	N/A	2/2	1/1		
18	If the investigation recommended programmatic and other actions,	100%	1/1	N/A	N/A	2/2	1/1	1/1	2/2		

	they occurred and they occurred timely.	7/7									

Comments:
16. For Individual #561 UIR 17572, disciplinary did occur, but was not included in the UIR.

17. For Individual #199 UIR 16678, the investigation identified staff had fraudulently documented room checks. No action, however, was taken with staff other than re-in-service. Also, it was not clear what efforts had been taken to identify which specific staff had fraudulently documented room checks.

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

18. Individual #300 UIR 15924 was a case where the individual was left unattended in a van. Given that this has happened at other Centers, the Monitoring Team asked about any Center-wide protocols that may have been put in place since this incident. The IMC reported that Abilene SSLC policy now required all vehicles be checked when drivers get out of the vehicle, and before drivers leave for the day. This was a Center-specific policy.

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

Summary: This outcome consists of facility indicators. Criteria were not yet met. Trend data and analysis were incomplete. There were not sufficient sets of data to enable meaningful analysis that could lead to identification of problem areas requiring remediation. Assistance from State Office would be helpful to the incident management and facility management staff. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	No									
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.	Yes									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									

Comments: 19-23. Not all aspects of data regarding abuse, neglect, injuries, and investigations were being collected. That being said, some action plans were put in place.

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	248	199	284	430	184	300	510	503	429
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.	50% 1/2	1/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered TIVA. b. On 7/31/17, and 12/7/17, Individual #248 received oral pre-treatment sedation. For these two instances of the use of oral pre-treatment sedation, informed consent was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and pre-procedure and post procedure vital signs were documented. In the ISP, dated 1/17/17, the IDT discussed the use of Halcion 0.5 milligrams (mg) and Ativan 2mg by mouth (PO). For the procedure on 12/7/17, IView showed administration of this combination of pre-treatment sedation. However, for the procedure on 7/31/17, IView showed administration of Valium 30 mg PO and 1 mg Ativan PO. From the documentation submitted, the Monitoring Team could not confirm that the IDT was consulted regarding this modification.											

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	50% 3/6	2/2	N/A	0/3	N/A	N/A	1/1	N/A	N/A	N/A
Comments: a. The Monitoring Team reviewed the use of oral pre-treatment sedation for the following individuals on the following dates: Individual #248 on 11/21/17, and 12/27/17; Individual #284 on 7/14/17, 8/11/17, and 12/8/17; and Individual #300 on 6/6/17. For each instance reviewed, informed consent was provided, and nursing staff documented pre- and post-procedure vital signs.											

However, for each of Individual #284's uses of oral pre-treatment sedation, 2 mg of Ativan was administered, but the IDT and Human Rights Committee had not approved Ativan, but rather approved the use of .5 mg of Halcion.

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: Monitoring of this outcome and its indicators is put on hold while the State develops instructions, guidelines, and protocols for meeting criteria with this outcome and its indicators.			Individuals:								
#	Indicator	Overall Score									
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.										
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.										
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.										
4	Action plans were implemented.										
5	If implemented, progress was monitored.										
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.										
Comments:											

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	51	431	86	432					
a.	For an individual who has died, the clinical death review is completed	75%	0/1	1/1	1/1	1/1					

	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.	3/4									
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, 11 individuals died. The Monitoring Team reviewed four deaths. Causes of death were listed as:

- On 6/24/17, Individual #472 died at the age of 89 of sepsis, bacteremia due to klebsiella, and urinary tract infection (UTI);
- On 7/3/17, Individual #558 died at the age of 64 of acute respiratory failure, stroke, and acute leukemia;
- On 7/9/17, Individual #431 died at the age of 85 of respiratory failure, bilateral pleural effusions with pulmonary edema, and advanced heart failure, and significant condition contributing to death: recurrent aspiration pneumonia;
- On 7/22/17, Individual #86 died at the age of 58 of advanced dementia, anorexia, and dysphagia leading to recurrent aspiration pneumonia, and contributing to death: Down Syndrome, declining muscle control, and inability to maintain postural position;
- On 9/19/17, Individual #51 died at the age of 31 of sepsis due to abdominal abscess;
- On 11/27/17, Individual #432 died at the age of 13 of respiratory failure, autonomic dysfunction, and encephalopathy related to intracranial bleed;
- On 12/9/17, Individual #510 died at the age of 63 of azotemia, anorexia, and cerebral ischemia with vascular dementia;
- On 1/9/18, Individual #315 died at the age of 58 of severe protein calorie malnutrition, dysphagia, and cerebral palsy;
- On 2/9/18, Individual #76 died at the age of 78 with causes of death pending;
- On 2/17/17, Individual #297 died at the age of 39 of with causes of death pending; and
- On 2/18/18, Individual #349 died at the age of 59 of with causes of death pending.

b. through d. As indicated in the last report, although it appeared that the mortality reviews resulted in some valuable recommendations, none of the mortality reviews reflected a comprehensive review of the care provided to the individual. As a result, it was not clear that the mortality review process identified a comprehensive set of recommendations to address existing issues. Some specific problems included:

- Individual #51's death should have triggered an hour-by-hour review of his last 24 hours at ABSSLC with both Medical Department and Nursing Department staff present to identify potential areas needing improvement. However, the Center staff

did not conduct such a review.

- The Center provided the Quality Assurance (QA) Death Review of Clinical Services reports for the individuals reviewed. These varied in terms of the quality of the analysis completed. Some identified important issues with regard to the nursing supports provided, but most often, the reports did not generate recommendations to address the issues identified.

e. For some of the recommendations, some continued improvement was noted with regard to conducting follow-up activity to measure the outcome of the interventions. For example, with regard to Individual #86's death, some of the recommendations required the development of processes to ensure nurses took appropriate actions (e.g., notifying PCPs of abnormal vital signs, and LVNs assessing and documenting acute care plan interventions). Based on documentation provided, the Nurse Manager Daily Report was modified for a couple months to include prompts to check for these items. What was not clear was whether or not this information was analyzed or aggregated to determine if the issue had resolved, or if further action was needed.

In addition, most Medical Department recommendations continued to require in-service training without follow-up to ensure that that Center practice had improved. For example, in relation to Individual #51's death, amongst other recommendations, the Medical Director was to "develop a process to ensure Progress Notes are completed/documented in IRIS for exchange of information regarding individual's condition," and "develop a process to ensure pre-treatment and post-sedation monitoring orders are completed and documented in IRIS." Both of these recommendations resulted in in-service training in the way of "reminders" to the PCPs without follow-up monitoring to ensure that concerning practices had been rectified, and/or the implementation of a plan for ongoing monitoring (i.e., not a one-time monitoring).

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: The Center did not appear to have a system to ensure that potential adverse drug reactions were reported immediately, further investigated, and probability scales completed. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	ADRs are reported immediately.	33% 1/3	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A	1/1
b.	Clinical follow-up action is completed, as necessary, with the individual.	33% 1/3		0/1				0/1			1/1
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	33% 1/3		0/1				0/1			1/1
d.	Reportable ADRs are sent to MedWatch.	33% 1/3		0/1				0/1			1/1
Comments: a. through d. For Individual #429, on 11/8/17, nursing staff notified the PCP of a potential ADR to Dalvance (i.e., vomiting											

and bloody diarrhea). The PCP took necessary clinical actions. On 11/21/17, the Pharmacy and Therapeutics Committee discussed it, and made the determination to send it to MedWatch, which occurred on 12/4/17.

The Monitoring Team identified two other potential ADRs for individuals reviewed. Center staff had not reported, and/or reviewed these potential ADRs. Specifically:

- On 11/7/17, Individual #199's prescription for Neurontin was discontinued, and she started on Vistaril. Neurontin was associated with peripheral edema, and increased leg pain. When she started on Vistaril, her leg pain improved.
- On 10/10/17, Individual #300 was hospitalized after a rapid change of mental status, including unresponsiveness. The hospital discharge summary listed: "metabolic encephalopathy secondary to medication, resolved" as the primary diagnosis.

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: N/A		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	
Comments: None.		

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Nineteen of these were moved to, or were already in, the category of requiring less oversight after the last review. Presently, five additional indicators will move to the category requiring less oversight. These are in the areas of ISPs, psychiatry, dental, and communication.

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

The Monitoring Team attended an ISP preparation meeting, Incident Management Review Team (IMRT) meeting, and various monthly IDT meetings.

<u>Assessments</u>
IDTs were doing a better job of identifying which assessments were needed, but they then failed to obtain these assessments in a timely manner prior to the ISP meeting.

The annual psychiatric clinical update with information for the ISP primarily appeared in the Annual Psychiatric Treatment Plan (APTP), which was prepared in sequence with the ISP. These documents contained the required information for every individual reviewed.

In behavioral health services, the collection of reliable data is a priority area, a pivotal activity, for the Abilene SSLC Behavioral Services Department. The lack of reliable data is a barrier to meeting a number of monitoring outcomes and indicators.

Behavioral health goals were based upon the individuals' functional behavior assessments. Functional assessments were current. One-third of the assessments met criteria for content, primarily due to absence of review of the individual's physical health over the previous year.

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

Since the last review, it was good to see improvement with regard to the timely completion of annual medical assessments for the individuals reviewed (i.e., Round 12 – 33%, and Round 13 – 89%). However, the Medical Department had suspended the completion of interim medical reviews through November 2017, which was a significant concern.

Although additional work was needed, the Center made progress with regard to the quality of medical assessments. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care consistent with relevant clinical guidelines or standards for each active medical problem, when appropriate.

As for the last two reviews, for the individuals reviewed, dental exams were completed timely. As a result, the related indicator will move to less oversight. In addition, it was good to see progress with regard to the quality of the annual dental exams and summaries.

Since the last review, it was positive that the Center's nursing staff had addressed the need for genitourinary exam information in nursing assessments. However, weight and fall information continued to be missing from many of the assessments. In addition, the Center's annual and quarterly nursing reviews contained the most specific clinical information that the Monitoring Team has seen since the implementation of IRIS, which was very positive, but nurses had not analyzed the risk areas to determine whether individuals' health conditions and risks were better or worse than last year, or had remained the same, and why. Work is also still needed to ensure that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.

Although some individuals' IDTs referred them to the PNMT when necessary, other individuals' IDTs did not, and the PNMT did not make self-referrals for these individuals. Therefore, the Center should continue to improve its performance with regard to timely referral of individuals to the PNMT, as well as the timely completion of reviews, and the completion of PNMT comprehensive assessments for individuals who need them. The quality of the PNMT comprehensive assessments needs improvement too. The PNMT should focus on collecting and analyzing data as the basis for determining the underlying cause(s) of individuals' physical and nutritional management issues. On a positive note, Registered Nurse (RN) Post Hospitalization Reviews were completed for the relevant individuals reviewed, and the PNMT discussed the results.

Often, Occupational Therapists (OTs)/Physical Therapists (PTs) did not complete timely assessments or consultations to address individuals' changing needs. The quality of OT/PT assessments continues to be an area on which Center staff should focus as well. Often, they included incomplete information and analyses, did not offer recommendations to address individuals' needs, and at times, appeared to show an acceptance for individuals' declines as opposed to recommending ways to enhance individuals' independence.

With a few exceptions, communication assessments generally were completed timely. However, the quality of communication comprehensive assessments and updates needed significant improvement.

About two-thirds of the individuals had current SAP-related assessments. Some SAPs had reliable data, an improvement from previous reviews. On the other hand, fewer SAPs were based on assessments results, or were practical, functional, or meaningful.

Individualized Support Plans
Regarding the creation of individualized personal goals in the ISP, the IDT created personal goals that met criterion for 16 of 36 personal goal areas (about the same as last time). One of the goals had reliable and valid data. Similar to the other Centers, good personal goals were not yet developed for the health and wellness/IHCP areas. Although IDTs had created the above goals, few had been implemented.

The set of indicators in Outcome #3 for ISPs looks broadly at the entire ISP's set of actions plans and action steps. In a sense, it is a review of the quality of the ISP. Some progress was seen. One individual had a 1 score for seven of the 11 indicators.

ISPs continued to be developed in a timely manner for new admissions, but relevant team members were missing from each individual's ISP meeting. However, a licensed member of the psychiatric team attended the ISP meeting for most of the individuals.

IDTs met routinely to review supports, services, and serious incidents. This was good to see, however, they rarely met again to ensure that recommendations were implemented. Some QIDP monthly reviews included data for some action plans, but did not include an analysis of those data to determine what specific progress had been made towards achievement of goals.

Although the scores do not yet portray it, Abilene SSLC made good progress in the development of psychiatry-related goals and psychiatric indicators. With some attention to the full wording of the goals, and with specification of an operational, observable, measurable definition of the psychiatric indicators that are in the goal, performance scores will likely improve. A more complicated task is to obtain reliable data on each psychiatric indicator.

PBSPs had many of the important components that one expects to find in a PBSP, however, they were also missing other equally important components, especially regarding individualized positive reinforcement.

The Monitoring Team has provided some comments (below in this report) regarding the way the respite house program was being implemented and with the way that the Ukeru program was being assessed.

Attention needs to be paid to ensure that actions are taken to support individuals to receive counseling services if that is what the IDT has proposed (as had been the case in the past at Abilene SSLC).

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 management support interventions.

On a positive note, the ISPs of individuals reviewed generally included a description of how the individual communicated and how staff should communicate with the individual. The related indicator will move to less oversight.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.												
Summary: Performance remained about the same. So, on the one hand it was good to see that Abilene SSLC continued to apply their ability to generate good, measurable goals to some individuals, for some of their goal areas. On the other hand, at this point, this ability should have continued to develop such that it applied to all individuals. In addition, similar to the other Centers, good goals were not yet developed for the health and wellness/IHCP areas for each individual. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	640	199	423	248	429	300				
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	4/6	2/6	4/6	1/6	3/6	2/6				
2	The personal goals are measurable.	0% 0/6	4/6	2/6	3/6	1/6	2/6	1/6				
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	1/6	0/6	0/6				

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #248, Individual #199, Individual #640, Individual #423, Individual #429, and Individual #300). The Monitoring Team reviewed in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Abilene SSLC campus.

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

indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

None of the six individuals had individualized goals in all areas. Therefore, none had a comprehensive set of goals that met criterion. For this set of individuals, however, the IDT had defined/chosen some personal goals that met criterion for being individualized, based on the individual's preferences and strengths. Overall, 16 of 36 personal goals met criterion for this indicator (about the same as last time). Goals that met criterion were:

- Individual #248's goals for greater independence.
- Individual #199's goals for recreation/leisure and greater independence.
- Individual #640's goals for recreation/leisure, relationships, work/day, and greater independence.
- Individual #423 goals for recreation/leisure, relationships, work/day, and greater independence.
- Individual #429's goals for recreation/leisure, relationships, and greater independence.
- Individual #300's work/day and greater independence goals.

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

2. Of the 16 personal goals that met criterion for indicator 1, 13 also met criterion for measurability (slightly lower than at the last review). The goals that also met this criterion were:

- Individual #248's goals for greater independence.
- Individual #199's goals for recreation/leisure and greater independence.
- Individual #640's goals for recreation/leisure, relationships, work/day, and greater independence.
- Individual #423 goals for recreation/leisure, work/day, and greater independence.
- Individual #429's goals for recreation/leisure and greater independence.
- Individual #300's work/day goal.

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

3. One of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. As noted throughout this report, for all of the other goals, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of data and documentation provided by the facility. While there were some data collected showing implementation of some action plans, there was not enough information documented to clearly determine the status of goals. The goal where implementation data were documented was:

- Individual #248's goal for greater independence.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.												
Summary: This set of indicators looks broadly at the entire ISP's set of actions plans and action steps. In a sense, it is a review of the quality of the ISP. Some progress was seen. For instance, of these 11 indicators, five stayed at 0% or 17%, however, the other six all had improved scores. Moreover, one individual (Individual #640) had a 1 score for seven of the 11 indicators. With continued attention to these aspects of the ISP, continued progress should be seen in future monitoring reviews. This set of indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	640	199	423	248	429	300				
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	2/6	0/6	0/6	1/6				
9	ISP action plans integrated individual preferences and opportunities for choice.	50% 3/6	1/1	0/1	0/1	0/1	1/1	1/1				
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1				
11	ISP action plans supported the individual's overall enhanced independence.	50% 3/6	1/1	0/1	1/1	0/1	0/1	1/1				
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1				
14	ISP action plans integrated encouragement of community participation and integration.	67% 4/6	1/1	0/1	1/1	1/1	0/1	1/1				
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	50% 3/6	1/1	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.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1				
17	ISP action plans were developed to address any identified barriers to	0%	0/1	0/1	0/1	0/1	0/1	0/1				

	achieving goals.	0/6									
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

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

Action plans, for the most part, did not support accomplishment of the individuals' personal goals. Many skill acquisition programs were never developed and for the ones that were, they did not include enough information to ensure that staff could consistently implement them and determine what progress was made. Service objectives did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress.

For the 16 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. Goals that met criterion were:

- Individual #423's recreation and greater independence goals.
- Individual #300's greater independence goal.

9. Three of the ISPs had action plans that integrated preferences and opportunities for choice. Individual #640 A, Individual #429, and Individual #300 had action plans that supported opportunities to make choices based on preferences. Although the action plans met criteria, none had been fully implemented. Individuals had little opportunity to make meaningful choices that might lead to greater independence. Preferences were somewhat limited for individuals in the review group. IDTs need to support individuals to experience new activities and expand their preferences.

10. One (Individual #640) of six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. A basis to making informed decisions is offering individuals exposure to a variety of new experiences and opportunities to make choices throughout their day. These opportunities were rarely included in action plans in any substantial way.

11. Three of six ISPs met criterion for this indicator to support the individual's overall independence.

- Individual #248 had a greater independence goal to knock on the door before entering a room. Staff reported that he had the skills to do this, but was not always compliant with doing it.
- Individual #199 had a goal to ride the city bus. This was a great goal to support her independence, however, action plans did not support accomplishment of the goal.
- Individual #300's goal to assist with putting on her shirt would give her a little more control over her day, however, communication seemed to be her greatest barrier to becoming more independent. A focus on communication strategies would support greater independence

12. None of the ISPs integrated strategies to minimize risks in ISP action plans. As noted above, IDTs failed to develop specific teaching

and support strategies to carry out action plans, thus, they did not have an avenue to integrate support strategies to address risks into action plans. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. An example of where supports to reduce risk were not integrated into the ISP included trends of peer-to-peer aggression for both Individual #248 and Individual #199. Neither of their ISPs included supports to minimize their risk, although both had been involved in numerous incidents.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well integrated in ISPs. In most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. Examples where discipline assessments and recommendations were not fully integrated included:

- Individual #199's IDT recommended integrating behavior and nursing supports to address her medication refusals and physical therapy and behavioral supports to address her decline in walking. It was not evident that collaboration among these disciplines had occurred.
- Communication strategies for Individual #429 were not integrated into her other action plans and teaching strategies.
- Individual #423's behavioral strategies were not integrated into her action plans for community outings.
- Recommendations by disciplines were cut and pasted into Individual #300's SAPs without being individualized from the action plan and were often not relevant.

14. Four ISPs included action plans that encouraged community participation and integration.

- Individual #248 had action plans to support his goal to participate in a walk-a-thon in the community.
- Individual #640 was attending school in the community.
- Individual #423 had a goal to work in the community, however, action plans did not support this goal. She did have an action plan to volunteer at Meals on Wheels in the community.
- Individual #300 had action plans to go shopping and have her nails and hair done in the community,

Individuals were rarely given opportunities to utilize community resources that might support them to be more independent and integrated into the community. For example, only one (Individual #300) of the individuals had goals for banking, volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movie, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. Three ISPs did not include action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.

- Individual #248's day program was not clearly defined or supported by his action plans.
- Individual #429. spent her days in her home. She had very few opportunities for training outside of her home.
- Individual #300 was working in the sheltered workshop and had a goal to obtain a job at McDonalds. While this was aspirational and good to see, only one action plan was consistently implemented (to continue working in the workshop). Her action plans were unlikely to lead to community employment.

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

new things. This was particularly true regarding employment.

16. Five ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional skill development. The assessment process was not adequate for assessing interests and skills outside of the limited training activities available at the facility. Individual #640 was in school and functionally engaged throughout the day. Observations did not support that Individual #248, Individual #199, Individual #423, Individual #429 or Individual #300 were engaged and learning new skills.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Individual #640's ISP preparation meeting was observed. The IDT reviewed his goals and noted that most of his action plans were never fully implemented. They did not address the previous year's barriers to implementation or to progress.

18. Action plans did not describe detail about data collection and review. Overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated, not individualized, and, in most cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented.

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

Summary: This set of 11 indicators looks more deeply at the living options discussion and team processes. Seven of the 11 were assessed for this review. Of these seven, three showed improved performance, three remained the same, and one decreased. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 640	199	423	248	429	300			
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	0/1	1/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community	67%	1/1	1/1	1/1	0/1	1/1	0/1			

	placement (or the individual was referred for transition to the community).	4/6									
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.	50% 3/6	1/1	1/1	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.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			
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 ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT. Individual #248's ISP identified living at ABSSLC as his preference, however, other statements regarding his environmental preferences did not support this. For example, it was noted that he does not like noise and crowds.

21. One ISP (Individual #429) included the opinions and recommendation of the IDT's staff members. For five others, assessments that included living option recommendations were not submitted prior to the ISP meeting for consideration or recommendations were not documented in the ISP.

22. Five ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. For Individual #248, it was not clear that the overall decision was based on his known preferences.

23. One of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #640 had recently been admitted to the facility and the team agreed that community placement should not be considered until his behavior stabilized. Other ISPs did not document discussion of community living options that might support their preferences and needs.

24. Four 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. For Individual #248 and Individual #300, obstacles were not clearly defined.

26. Three individuals had individualized, measurable action plans to address obstacles to referral. For Individual #248 and Individual #300, obstacles were not clearly defined and for Individual #423, her IDT did not develop measurable action plans to address obstacles.

28. Two of the ISPs had individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs when lack of awareness was identified as a barrier. Individual #429 and Individual #300 had measurable action plans for further exposure to living options.

29. None of the individuals were referred to the community.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISPs continued to be developed in a timely manner for new admissions. Therefore, indicator 31 will be moved to the category of requiring less oversight. Relevant team members were missing from each individual's ISP meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	248	429	300			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	1/1	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.	17% 1/6	0/1	1/1	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).	50% 3/6	0/1	1/1	1/1	0/1	0/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
31. Individual #640 was admitted to the facility over the past year. His ISP was developed within 30 days of his admission.

32. Documentation was not submitted that showed that action plans were implemented within a timely basis. QIDP monthly reviews indicated that a majority of goals were either never implemented or not consistently implemented. This is a repeat finding from the last review.

33. Three individuals attended their ISP meetings. Individual #248, Individual #640, and Individual #429 did not attend their ISP meeting.

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

- For Individual #248, his SLP did not participate in his ISP meeting.
- Individual #640's LAR did not participate in his ISP meeting.
- Individual #300's OT/PT was not present at her ISP meeting.

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

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: IDTs were doing a better job of identifying what assessments were needed (indicator 35), but they then failed to get these assessments in a timely manner prior to the ISP meeting (indicator 36). Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	248	429	300			
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.	100% 5/5	N/A	1/1	1/1	1/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			

Comments:
35. The IDT considered what the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting for all individuals. Individual #640 was recently admitted, thus, he did not have an ISP preparation meeting where that discussion would be documented.

36. One of the IDTs (Individual #429) arranged for and obtained all needed, relevant assessments as identified by the IDT prior to the ISP meeting.

- Individual #248's vocational, behavioral, and OT/PT assessments were not submitted at least 10 days prior to his ISP meeting according to QIDP data.
- Individual #423's behavioral, psychiatry, and functional skills assessment were not submitted timely.
- Individual #300's behavior, psychiatry, day and OT/PT assessments were submitted late.
- Individual #640's behavioral, psychiatry, dental and functional skills assessments were not submitted at least 10 days prior to his ISP meeting according to QIDP data.
- Individual #199's behavioral assessment was submitted late.

The facility reported that 19% of Annual Medical Assessments were submitted 10 days prior to the ISP meeting. They had developed a corrective action plan to address the timeliness of medical assessments. Without updated assessments available to the IDT, it was unlikely that all risks and necessary supports were addressed through the ISP process.

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	640	199	423	248	429	300			
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 routinely to review supports, services, and serious incidents. This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure that recommendations were implemented. Furthermore, reliable and valid data were rarely available to guide decision-making.

IDTs rarely revised goals when progress was not evident. ISPs were not fully implemented for any individual. IDTs sometimes discontinued goals that were not being implemented, however, did not meet to revise goals or address barriers to prior implementation.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals. QIDP monthly reviews included little meaningful information regarding progress towards goals and efficacy of supports. When additional assessments were recommended throughout the ISP year, if was often not apparent that the IDT obtained those assessments, reviewed any resulting recommendations, and/or implemented changes to supports when recommended.

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

The Monitoring Team attended a number of meetings while onsite to review the IDT process and the facility response to incidents. 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 within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	The individual's risk rating is accurate.	28% 5/18	0/2	1/2	0/2	1/2	0/2	0/2	1/2	2/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	50% 9/18	1/2	0/2	0/2	2/2	2/2	1/2	1/2	1/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #248 – falls, and choking; Individual #199 – gastrointestinal (GI) problems, and weight; Individual #284 – falls, and constipation/bowel obstruction; Individual #430 – infections, and constipation/bowel obstruction; Individual #184 – aspiration, and fractures; Individual #300 – choking, and falls; Individual #510 – falls, and constipation/bowel obstruction; Individual #503 – skin integrity, and other: hypothermia; and Individual #429 – falls, and infections].

a. The IDTs that effectively used supporting clinical data, and used the risk guidelines when determining a risk level were those for Individual #199 – GI problems; Individual #430 – infections; Individual #510 – falls; and Individual #503 – skin integrity, and other: hypothermia.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #248 – choking; Individual #430 – infections, and constipation/bowel obstruction; Individual #184 – aspiration, and fractures; Individual #300 – choking; Individual #510 – constipation/bowel obstruction; Individual #503 –other: hypothermia; and Individual #429 – falls.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: Although the scores don't yet portray it, Abilene SSLC made good progress in the development of psychiatry-related goals and psychiatric indicators. With some attention to the full wording of the goals, and with specification of an operational, observable, measurable definition of the psychiatric indicators that are in the goal, performance scores on indicators 4, 5, and 6 will likely improve (note that indicator 6 scored at 56%). Indeed, Abilene SSLC is on the cusp of doing so for all individuals. A more complicated task is to obtain reliable data on each psychiatric indicator (indicator 7). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
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.	56% 5/9	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1	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:
The Abilene SSLC psychiatry department continued to make good progress in developing psychiatry-related goals for individuals. This outcome contains four indicators that each get at an important aspect of the goals. Each will be discussed in turn below.

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

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

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder. Psychiatric indicators can be psychometrically sound rating scales, and/or data collection recordings of symptoms directly observed by SSLC staff. Psychiatric indicators need to be directly related (derived from) the individual's diagnosis or diagnoses. Individuals should have psychiatric indicators (and goals) that are related to the reduction of psychiatric symptoms <u>and</u> goals/objectives related to the increase of positive/desirable behaviors.

Goals for behavioral health services typically appear in the functional assessment and/or the PBSP. Goals for psychiatry typically appear in the annual psychiatry update and/or quarterly psychiatry clinic review reports. Goals for behavioral health services and for psychiatry ultimately need to appear in the behavioral health risk section of the IHCP.

4. The Monitoring Team looks at the set of goals for each individual. Goals must include the focus of the goal (i.e., psychiatric indicators), address the reduction of symptoms and the increase of prosocial behaviors, and include criterion.

At Abilene SSLC, goals for none of the individuals met all of the criteria, however, there was excellent progress as described in some detail below, along with specific feedback and suggestions from the Monitoring Team.

- All of the individuals had identified psychiatric goals that were related to their psychiatric disorder. These goals appeared first either in a quarterly review or the APTP and then were carried forward in future quarterlies.
- All of the individuals had negative psychiatric indicators identified for decrease. In addition, six of the individuals (i.e., not Individual #199, Individual #561, and Individual #248) had prosocial goals of behaviors to increase.
- The psychiatric team had identified the derivation for each goal that explained the relationship between the psychiatric indicator and the underlying psychiatric diagnosis.
- Some goals had a desired number of occurrences (e.g., maintain at four or less incidents of aggression per month, maintain at >95% per month), and a length of time (e.g., for the quarter, for six consecutive months). This was good to see, but needs to be applied to all goals for all individuals. Some goals, however, merely stated maintain current stability, or decrease, for example. The goals also need to have a desired end time (e.g., by December 31, 2018). None of them had this latter item.
- Some goals showed good progress towards operational definitions of the psychiatric indicators. For example, rather than solely writing "suicidal threats," the indicator defined this for the individual ("Stating she is going to kill herself or do something that could potentially result in death. Ingesting harmful substances such as shampoo, pills, cleaning fluid or other chemicals; cutting herself; trying to cut out her tongue; jumping out of a moving vehicle; jumping in front of a moving vehicle; or any other act that could potentially result in death."). This, however, was not the case for all psychiatric indicators. Some merely said depressive mood, psychotic symptoms, or behavior crisis. For Individual #49, for example, the psychiatric indicator of emotional outbursts was not operationally defined in a manner that would lead to reliable data.
    - In some cases, the psychiatric indicator was the same as the PBSP target behavior. In most of those cases, there was a sufficient operational definition.
- Goals need to appear in the IHCP section of the ISP. This was not yet the case.

5. Goals must be measurable. That is, the psychiatric indicators in each goal must be observable and measurable. They must be designed so that their reliability can be determined.

- Many goals included some detail in the definition (operationalization) of the psychiatric indicator as noted above in indicator 4. In order for the goal to be measurable, the definition (operationalization) needs to more clearly describe exactly what it is that the person recording information needs to see. This is typically direct support professional staff, but sometimes might be behavioral health services staff or psychiatry staff (e.g., for rating scales). Those recorders need to know how to determine if a psychiatric indicator (symptom) is or is not occurring and if it should or should not be counted.
- The psychiatry documentation should include a specific operational, observable, measurable description of the psychiatric indicators included in the goals.

6. Goals (and their psychiatric indicators) must be related to the individual's assessment and diagnosis.

- At Abilene SSLC, goals were related to the individual's assessment and diagnosis or diagnoses for about half of the individuals. The Monitoring Team does not require that there be a separate goal for reduction and a separate goal for increase for every diagnosis.
- The facility performed periodic thorough assessments in the form of the CPEs as well as the Annual Psychiatric Treatment Plan updates. The goals for five individuals were based on these assessments.

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

- Data were being collected for PBSP target behaviors, some of which were also designated as psychiatric indicators. The behavioral data that were generated at Abilene SSLC were not found to be reliable.
- There was no system to adequately collect or assess the reliability of the data on psychiatric indicators (that were not also target behaviors in the PBSP).
- Ensuring reliable data is an area of focus for the psychiatry department. Likely, accomplishing this will require collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: There was some improvement in indicator 16 and lower performance on indicator 15. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.										
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the	50% 1/2	1/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A

	primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.										
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.	67% 6/9	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1

Comments:

15. Individual #640 and Individual #561 had been admitted to the facility within the past two years. Both of these individuals had a CPE that had been completed within 30 days of admission. There was an IPN in the record of Individual #640 within the required time frame, but for Individual #561, the admission IPN was not completed until five days after admission. In that note, the nurse indicated that she had not been notified of the admission.

16. The psychiatric diagnoses were consistent throughout the medical record for all of the individuals with regard to the diagnosis found in the psychiatric and behavioral sections. The diagnosis found in the medical section of the record varied from that in the behavioral and psychiatric sections for Individual #640, Individual #561, and Individual #248.

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

Summary: With sustained high performance, all three of these indicators might be moved to the category of requiring less oversight after the next review. Of note, psychiatry information in the ISP (IRRF section) was greatly improved since the last review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 640	199	423	2	49	561	154	474	248
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

18. The annual clinical update with information for the ISP primarily appeared in the Annual Psychiatric Treatment Plan (APTP), which was prepared in sequence with the ISP. These documents contained the required information for every individual. Individual #640 did

not have an ATPT due to his recent admission and the admission CPE served this function.

20. The current review indicated that a licensed member of the psychiatric team had attended the ISP meeting for all of the individuals, except Individual #474. The available documentation during the onsite review indicated that the IDT Team had determined during the pre-ISP meeting that the psychiatric provider did not need to attend the ISP for Individual #474. The review of this documentation indicated that the only comment in the ISP Preparation document related to the rationale for this decision was the comment "no issues," which was not consistent with the observation that he was prescribed polypharmacy with a number of psychiatric medications.

21. The documentation in the ISPs was found to contain the essential elements for all of the individuals, except Individual #640. This represents significant progress from prior reviews. The innovation that appears to have facilitated this improvement was the inclusion of the detailed information from the ATPT into the behavioral health section of the IRRF.

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: 100% scoring was obtained for all three indicators. This level of performance was maintained for this review and the past two reviews, too, for indicators 31 and 32, both of which will be moved to the category of requiring less oversight. With sustained high performance, indicator 30 might also be moved to this category after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.										
30	A risk versus benefit discussion is in the consent documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and/or non-	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	pharmacological interventions that were considered.	9/9									
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:
30. There was an adequate risk benefit discussion in the consent for each of the individuals. Both the discussion of the side effects and risk benefit analysis were facilitated by the inclusion of the most recent Annual Psychiatric Treatment Plan in the material provided to the guardian.

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. The reviews by the Human Rights Committee were present.

Psychology/behavioral health

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

Summary: Both indicators will remain in active monitoring, though with sustained high performance, indicator 4 might be moved to the category of less oversight after the next review. The collection of reliable data is a priority area, a pivotal activity, for the Abilene SSLC behavioral services department. The lack of reliable data is a barrier to meeting a number of monitoring outcomes and indicators. Indicator 5 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 640	199	423	2	49	561	154	474	248
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	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	individual's status and progress.	0/9									

Comments:
4. For all nine individuals, the goals were based upon their functional behavior assessments. It should be noted that Individual #640's FBA noted his taking off his clothing and taking others' food/belongings, neither of which were addressed in his PBSP. All of the identified problem behaviors displayed by Individual #423 were addressed in her PBSP, but it also targeted suicidal behaviors, which were not included in her FBA.

5. Reliable and valid data were not available to assess individual progress or the lack thereof. While inter-observer agreement was regularly assessed, timely recording of data remained a problem.

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

Summary: Performance on these three indicators has been up and down across this and the previous three reviews. With some attention, it is likely that more stable (and high) performance could be achieved. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 640	199	423	2	49	561	154	474	248
10	The individual has a current, and complete annual behavioral health update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	33% 3/9	1/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments:
10. All nine individuals had a current behavioral health update. However, eight of these reports did not include a review of the individual's physical health over the previous year. The exception was the report for Individual #423. Additionally, the reports for seven individuals did not provide the individual's intelligence testing score or value. The exceptions were the reports for Individual #561 and Individual #474. The tool used to assess cognitive abilities was identified in Individual #474's assessment only.

In the past, reports included the score/value and identified the instrument that had been used to assess cognitive abilities. Although not one of the indicators, it's important to note that the behavioral health assessment was available to the IDT 10 days prior to the individual's meeting in two cases, Individual #561 and Individual #154. (This information was based on the data provided by the QIDP).

Several of the behavioral health assessments were not dated or signed. Both of these are necessary to ensure that his historical record is accurate and informative

11. All of the nine individuals had a current functional behavior assessment.

12. The FBA was considered complete for three individuals, Individual #640, Individual #423, and Individual #561. Although direct observations were completed for Individual #199, Individual #49, Individual #154, and Individual #474, no problem behaviors were observed. There was no statement as to why additional observations were not necessary. The indirect assessments completed for Individual #2 and Individual #248 did not address all of their targeted problem behaviors.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: PBSPs had many of the important components that one expects to find in a PBSP, however, they were also missing other equally important components, especially regarding individualized positive reinforcement. Comments are provided below regarding the way the respite house program was being implemented and with the way that the Ukeru program was being assessed. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	44% 4/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. Based upon the consent tracking information provided by the facility, four of the nine PBSPs were implemented within 14 days of all consents. These were the PBSPs for Individual #2, Individual #154, Individual #474, and Individual #248. For all others, the PBSP was implemented before all applicable consents had been obtained.

15. Although none of the PBSPs were considered complete, several indicators were met in six or more of the plans. These included operational definitions of targeted problem behaviors and functionally equivalent replacement behaviors, antecedent and consequent strategies, guidelines for training/reinforcing replacement behaviors, and treatment objectives. Elements that were missing included the use of positive reinforcement in a manner likely to affect behavior change and sufficient opportunities for replacement behavior to be reinforced.

Although one of Individual #154's primary problem behaviors was his refusal to wear clothing, this was not tracked or addressed in his PBSP. When a request was made for data on the amount of time he was naked while awake, the facility could not provide this information. Instead, data regarding his wearing clothing SAP were provided. Data indicated that less than one trial was implemented across the total number of days in each month between June 2017 and January 2018. Because each trial is for three minutes, this provided very little opportunity for an improvement in this behavior.

Regarding respite house: During the six-month period prior to the onsite visit, one individual, Individual #561, had been placed in respite. According to the respite log provided by the facility, he arrived on the afternoon of 1/29/18 and remained in the home until 2/8/18. As reported by the behavioral health services director, Individual #561 had threatened to kill one of his housemates. Included in the log was documentation from seven of the 11 days he spent in this setting. There was no explanation for documentation missing from 2/3/18 through 2/6/18. Based on the form used, it was not clear that Individual #561 left this space with the exception of reported visits to his new home.

Following the State's review of the draft version of this report, the Center provided the following documentation: minutes from an ISPA meeting during which the IDT approved the use of respite, the individual's Crisis Intervention Plan that included the use of the respite home, dates of review of the CIP by behavioral services and the Human Rights Committee, minutes from the Restraint Reduction Committee including a review of the use of the respite home, and logs maintained while individual #561 was in the respite home.

This documentation was very helpful. The documentation, however, was not fully complete, but should be, given the restrictive nature of this intervention. For example, the CIP itself did not include the implementation date or the date of HRC review, and some of the logs from the respite home were missing information regarding meals, contained no information from a shift, etc. While there were some notations of the individual leaving to visit his new home, it would be helpful if the time in and out of the home was documented daily. In one case, dinner consisted of a sack lunch. There should be a reason provided for this substitute meal.

Another concern raised when reading the logs was a discrepancy between staff and Individual #561 regarding his moving day. When Individual #561 repeatedly commented that he was moving on that specific day, staff indicated they pivoted and would ask the BCBA when he/she arrived. As this was a major change in Individual #561's life, it is suggested that staff should have offered to call the appropriate person to obtain confirmation of his moving day.

Regarding Ukeru: Since the last visit, the Ukeru program for reducing the use of restraint had been introduced in several homes. When this was observed by Monitoring Team, concerns were raised regarding the number of staff and the positioning of blocking pads. On one occasion, Individual #423 was observed with a staff member sitting on an adjacent couch with several pads clearly visible in the immediate environment. Another observation occurred where three staff members were standing around Individual #423. During both observations, problem behavior was not observed. To an outside observer, there was a sense of implied intimidation. The Ukeru report submitted by the behavioral health services director consisted of graphs for the two pilot homes (6380 and 6400). Individual data were not submitted, rather graphs depicted home totals for the following: Ukeru methods utilized, restraints, aggression, self-injurious behavior, client injuries, staff injuries, and client allegations. An additional graph depicting workers' compensation claims in home 6400 was provided. While graphs for individuals would be more informative, data suggested increases in aggression, self-injury, and client injuries after Ukeru was introduced in home 6400. Other graphs suggested a decreasing trend in the target behavior prior to the implementation of the Ukeru program. Because group data can mask individual response to this intervention, it would be important to analyze the impact of the approach on individuals. To this point, it would be helpful for individual graphs to include a phase change line when this intervention was implemented.

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

Summary: Attention needs to be paid to ensure that actions are taken to support individuals to receive counseling services if that is what the IDT has proposed (as had been the case in the past at Abilene SSLC). For the one individual who had counseling services, one aspect of her plan was missing. The Monitoring Team will leave these indicators in the category of requiring less oversight, however, performance needs to improve or it is possible that they may be returned to active monitoring after the next review.			Individuals:								
#	Indicator	Overall Score									
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.										

Comments:
24. The IDTs for three of the nine individuals reviewed had recommended counseling services. At the time of the visit, only Individual #423 was still enrolled in this service. Individual #199 and Individual #561 were no longer participating. There was no evidence of steps taken to identify another provider, including counselors located in the community.

25. The counseling plan for Individual #423 was complete with the exception of plans to generalize her learned skills to environments outside of counseling. She was expected to verbalize how she could use her skills in other settings, but this did not constitute a plan to ensure that she did use her learned skills. There was a data based review of her progress.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Since the last review, it was good to see improvement with regard to the timely completion of annual medical assessments for the individuals reviewed (i.e., Round 12 – 33%, and Round 13 – 89%). However, the Medical Department had suspended the completion of interim medical reviews through November 2017, which was a significant concern. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
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	89%	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

	completed within 365 days of prior annual assessment, and no older than 365 days.	8/9									
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: c. In response to the request for interim medical reviews, the Center submitted statements indicating: "No interim medical reviews for this time period. Interim medical reviews were suspended and were not reinstated until November 2017." This was concerning.

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.

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.

#	Indicator	Overall Score	Individuals: 248	199	284	430	184	300	510	503	429
a.	Individual receives quality AMA.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1
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 individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that two individuals' AMAs (i.e., Individual #510, and Individual #503) 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 pre-natal histories, social/smoking histories, childhood illnesses, past medical histories, complete interval histories, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, pertinent laboratory information, and updated active problem lists. Most, but not all included, as applicable, family history, and allergies or severe side effects of medications. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care consistent with applicable clinical guidelines or current standards 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 #248 – cardiac disease, and other: pica; Individual #199 – cardiac disease, and gastrointestinal (GI) problems; Individual #284 – constipation/bowel obstruction, and falls; Individual #430 – fractures, and seizures; Individual #184 – GI problems, and other: urological obstruction; Individual #300 – fractures, and constipation/bowel obstruction; Individual #510 – seizures, and weight;

Individual #503 – respiratory compromise, and GI problems; and Individual #429 – respiratory compromise, and osteoporosis].

As noted above, in response to the request for interim medical reviews, the Center submitted statements indicating: "No interim medical reviews for this time period. Interim medical reviews were suspended and were not reinstated until November 2017." In addition, the ISPs/IHCPs reviewed generally did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. The one exception was the IHCP for Individual #510 for seizures.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
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.	28% 5/18	0/2	0/2	1/2	1/2	0/2	0/2	2/2	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.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #248 – cardiac disease, and other: pica; Individual #199 – cardiac disease, and GI problems; Individual #284 – constipation/bowel obstruction, and falls; Individual #430 – fractures, and seizures; Individual #184 – GI problems, and other: urological obstruction; Individual #300 – fractures, and constipation/bowel obstruction; Individual #510 – seizures, and weight; Individual #503 – respiratory compromise, and GI problems; and Individual #429 – respiratory compromise, and osteoporosis).

The IHCPs that sufficiently addressed the chronic or at-risk condition in accordance with applicable medical guidelines or standards were those for: Individual #284 – constipation/bowel obstruction; Individual #430 – seizures; Individual #510 – seizures, and weight; and Individual #503 – respiratory compromise.

b. As noted above, the ISPs/IHCPs reviewed generally did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. The exception was the IHCP for Individual #510 – seizures.

Dental

<table>
<tr><td colspan="12">Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.</td></tr>
<tr><td colspan="3">Summary: Given that over the last two review periods and during this review, for the individuals reviewed, the Dentist completed timely dental examinations (Round 11 – 100%, Round 12 – 100%, and Round 13 – 100%), Indicator a.ii will move to the category requiring less oversight. It was good to see improvement in the quality of dental exams and summaries. The remaining indicators will continue in active oversight.</td><td colspan="9">Individuals:</td></tr>
<tr><td>#</td><td>Indicator</td><td>Overall Score</td><td>248</td><td>199</td><td>284</td><td>430</td><td>184</td><td>300</td><td>510</td><td>503</td><td>429</td></tr>
<tr><td>a.</td><td>Individual receives timely dental examination and summary:</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.</td><td>N/A</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.</td><td>100%
9/9</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td></tr>
<tr><td></td><td>iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.</td><td colspan="10">Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.</td></tr>
<tr><td>b.</td><td>Individual receives a comprehensive dental examination.</td><td>78%
7/9</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>0/1</td><td>0/1</td><td>1/1</td><td>1/1</td></tr>
<tr><td>c.</td><td>Individual receives a comprehensive dental summary.</td><td>89%
8/9</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>0/1</td><td>1/1</td><td>1/1</td></tr>
<tr><td colspan="12">Comments: a. It was positive that for the nine individuals reviewed, the Dentist completed timely dental examinations.

b. It was positive that for seven of the nine individuals reviewed, the dental exams included all of the required components. The following problems were noted:
• Individual #300 had 16 teeth, but both the odontogram and dental summary indicated that she had 17 teeth.
• Individual #510 did not have a periodontal chart.

c. It was positive that for eight of the nine individuals reviewed, the dental summaries included all of the required components. Individual #510's dental summary did not identify dental conditions that could cause systemic health issues or are caused by systemic health issues.</td></tr>
</table>

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
Summary: Since the last review, it was positive that the Center's nursing staff had addressed the need for genitourinary exam information in nursing assessments. However, weight and fall information continued to be missing from many of the assessments. In addition, the Center's annual and quarterly nursing reviews contained the most specific clinical information that the Monitoring Team has seen since the implementation of IRIS, which was very positive, but nurses had not analyzed the risk areas to determine whether individuals' health conditions and risks were better or worse than last year, or had remained the same, and why. Work is also still needed to ensure that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	45% 5/11	0/1	1/2	0/2	N/A	1/2	0/1	1/1	1/1	1/1
Comments: a. The Nursing Department appropriately addressed the issue of the missing genitourinary exam in IView by adding assessment findings to the narrative section of the annual nursing review entitled Physical Evaluation/Assessment Results. The Center's annual and quarterly nursing reviews contained the most specific clinical information that the Monitoring Team has seen since											

the implementation of IRIS, which was very positive. However, producing assessments up to 54 pages in length made it challenging for the nurses to analyze the risk areas to determine whether individuals' health conditions and risks were better or worse than last year, or had remained the same, and why. In addition, the lists of weights were not included within the annual and quarterly nursing reviews, nor were they provided as a separate document. A current weight was usually provided in the "Weight" risk section, but not a list of weights for each month of the year and quarter to show the variations from month to month. In addition, some annual and quarterly reviews did not include fall assessments.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #248 – falls, and choking; Individual #199 – GI problems, and weight; Individual #284 – falls, and constipation/bowel obstruction; Individual #430 – infections, and constipation/bowel obstruction; Individual #184 – aspiration, and fractures; Individual #300 – choking, and falls; Individual #510 – falls, and constipation/bowel obstruction; Individual #503 – skin integrity, and other: hypothermia; and Individual #429 – falls, and infections).

Overall, none of the annual comprehensive nursing assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, on a positive note, for half of the risk areas reviewed, nurses included status updates, including relevant clinical data (i.e., Individual #199 – GI problems; Individual #430 – infections, and constipation/bowel obstruction; Individual #184 – aspiration, and fractures; Individual #510 – constipation/bowel obstruction; Individual #503 – skin integrity, and other: hypothermia; and Individual #429 – infections). Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year, and/or made recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

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

- An IPN, dated 12/15/17 at 1:44 p.m., noted that Individual #248 fell. The nurse provided no other details, such as whether or not staff saw the individual fall, where it happened, or how it happened. Based on the documentation provided, the nurse essentially did not conduct a nursing assessment or note the individual's vital signs.
- On the following dates: 8/10/17, 8/11/17, 8/15/17, 8/16/17, and 8/21/17, although the IPNs noted that Individual #199 made several complaints of leg cramps and pain, there was no indication that nursing staff assessed for lower extremity edema before administering Tylenol PRN.
- According to data from TX-AB-1802-IV.1-20, on 11/15/17, Individual #284 fell. No IPN addressing a fall was found. However, an IPN, dated 11/16/17 at 7:57 p.m., indicated staff found a bruise to her left buttock. Based on the IPN, nursing staff did not document an assessment of pain, changes in gait, or the rest of her skin.
- An IPN, dated 10/23/17, indicated direct support professional staff reported that Individual #184 fell on his right knee. No other details were provided regarding where he fell, if he complained of being dizzy or weak, or lost his balance. The documented nursing assessment did not address swelling, skin temperature, or other injuries or pain experienced.
- An IPN, dated 10/4/17, indicated that staff notified the nurse that Individual #300 fell and stood up on her own. No details were provided regarding where she fell, what she was doing at 4:00 a.m. when she fell, whether the fall was witnessed (if it was not witnessed, then a full assessment would be needed, she should not have been moved unnecessarily, and the PCP should

have been notified), any complaints of dizziness, if vital signs were taken at the time, the time the nurse assessed her (i.e., the IPN was entered at 2:18 p.m.), and her status throughout the day, since the IPN was written hours after the incident. The next RN monthly IPN, dated 10/4/17 at 8:28 p.m., noted Individual #300 had not had any falls that month, so it appeared that the RN was not aware of the individual's fall that morning.

The RN IPN, dated 10/6/17 at 11:14 a.m., noted that the individual was not eating meals, had been in bed for the past four to five days, had stiffness in her legs, "asked for help from different persons including this nurse but when assisting refuses to help herself or DSP [direct support professional] to stand up." The note indicated Individual #300 was rubbing on left hip as if injured, but "No injuries noted. No redness, swelling, bruising, noted to hip area. No recent falls." At 5:22 p.m. the same day, the RN added an addendum to this IPN noting the fall on 10/4/17, notifying the PCP of the fall, and indicating the individual was sent for x-rays. The note also indicated that Individual #300 had "dark black, red and yellow bruising underneath butt cheek area bilaterally" after the initial x-rays were taken, but the note did not identify who discovered the bruising. This note also indicated that the PCP was notified and ordered additional x-rays. A Nurse Practitioner IPN, dated 10/6/17 at 3:04 p.m., indicated that the RN reported the fall on 10/3/17 (date should be 10/4/17), and that Individual #300 had been ambulating without problems, but "has spells of complaints of pain." This, however, was not what was reflected in the Communication Log, according to the ISPA, dated 10/7/17. The notes from the Communication Log for 10/5/17 indicated that Individual #300 could not sit up in bed when prompted to get her medications and that when assisted up to the medication room, "it seemed as if her legs gave out." The Log indicated that staff assisted Individual #300 to the floor and the home nurse assessed her. No IPN documentation was found to support the nurse assessing her.

The results of the x-rays indicated that Individual #300 had a L3 50% compression fracture. An ISPA, dated 10/17/17, indicated that since the fall, the individual had been refusing to get out of bed for meals, activities, and was having difficulty getting up to use the bathroom, as well as not being able to sit on the toilet. After attempts to do so were unsuccessful, Individual #300 would request to lie back down. The documentation provided did not indicate how she was going to the bathroom. However, a temporary PNMP was not implemented until 10/10/17, addressing how staff were to modify the assistance they provided to Individual #300 for bed mobility and transfers. On 10/10/17 at 12:10 p.m., she was sent to hospital via 911 for lethargy and "not being able to breathe on her own." She was diagnosed with a urinary tract infection (UTI) positive for gram negative rods and E. coli. In addressing Individual #300's change(s) of status, the documentation showed a significant lack of assessment, communication, prompt interventions, and training amongst the team members and residential staff.

On a positive note:

- For Individual #199, a nursing IPN, dated 8/28/17, contained a good nursing assessment of a vomiting episode.
- For Individual #184, an IPN, dated 10/22/17, noted complaints of a sore throat. The IPN documented a complete nursing assessment.
- IPNs, dated 7/23/17, from the LVN and RN regarding Individual #510's fall from the wheelchair onto the bathroom floor contained complete nursing assessments and documented appropriate notification of the PCP.
- IPNs, dated 7/21/17 at 4:11 p.m. from the RN, and at 3:43 p.m. from the LVN, noted a pressure area to Individual #503's Mic-Key stoma. Nursing assessments were complete, and the IPNs documented appropriate notification of the PCP. However, it was concerning that other nurses did not notice the area prior to its breakdown.

- For Individual #429, in an IPN, dated 10/31/17, the nurse noted green drainage from the VNS incision, and documented a complete assessment that included PCP notification and transfer to the ED via 911.

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 several review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	11% 2/18	0/2	1/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	11% 2/18	0/2	1/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2

Comments: b. The IHCPs that included preventative measures were for Individual #199 – GI problems, and Individual #430 – infections. At times, IHCPs included nursing interventions, but they did not conform with current generally accepted standards because they did not include all relevant assessment criteria, and/or were not frequent enough given the individual's level of risk.

c. The IHCPs that included measurable objectives to allow the team to track progress were for Individual #199 – GI problems, and Individual #430 – infections.

e. The IHCP that included the specific clinical indicators to be monitored was for Individual #430 – infections.

f. The IHCP that stated the frequency of monitoring/review of progress was for Individual #430 – infections.

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, Registered Nurse (RN) Post Hospitalization Reviews were completed for the relevant individuals reviewed, and the PNMT discussed the results. If the Center's high performance in this regard continues, then Indicator e might move to the category of less oversight after the next review. The Center should continue to improve its performance with regard to timely referral of individuals to the PNMT, timely completion of reviews, and completion of PNMT assessments for individuals who need them. The quality of the PNMT comprehensive assessments needs improvement as well. The PNMT should focus on collecting and analyzing data as the basis for determining the underlying cause(s) of individuals' physical and nutritional management issues. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	67% 4/6	N/A	0/1	1/1	1/1	1/1	N/A	0/1	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	75% 3/4		1/1	1/1	N/A	N/A		1/1	0/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	60% 3/5		1/1	0/1	1/1	1/1		0/1	N/A	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	67% 4/6		1/1	0/1	1/1	1/1		0/1	1/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 2/2		N/A	N/A	1/1	1/1		N/A	N/A	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/6		0/1	0/1	0/1	0/1		0/1	0/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings;	0% 0/1		N/A	N/A	N/A	N/A		N/A	0/1	

	• Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5		0/1	0/1	0/1	0/1		0/1	N/A	

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

- Between January 2017 and July2017, Individual #199 experienced 23 episodes of emesis, but it was not until August 2017, when 27 episodes of emesis occurred that her IDT referred her to the PNMT. The PNMT initially conducted a review, but when Individual #199 was diagnosed with aspiration pneumonia, they transitioned to completing a full assessment.
- For Individual #284, the PNMT did not conduct an assessment to address her falls. Between March 2017 and May 2017, she fell 12 times, and between July 2017 and December 2017, she fell 22 times. Although some of her falls potentially had a behavioral component in that they occurred when she resisted assistance, it did not appear that the PNMT collaborated with Behavioral Health Services. In addition, at one time, there was suspicion that staff were inaccurately documenting falls that were actually Individual #284 sitting down. It would have been important for the PNMT to assist the IDT in designing data collection methodologies with clear functional definitions of both. Further, the 6/22/17 PNMT notes indicated that some falls were a result of other individuals tripping or pushing Individual #284, and that these would not be counted towards meeting the threshold for PNMT involvement, and that the PNMT would not be notified. These types of falls are no less important, and might indicate that an individual's ability to recover from being thrown mildly off balance is an issue.
- After Individual #430 was diagnosed with aspiration pneumonia on 4/20/17 during a hospitalization for a fracture of the bilateral proximal humeral head (i.e., hospitalization from 4/18/17 to 4/26/17), the PNMT appropriately changed from conducting a review of the fracture to completing a full assessment for both thresholds that he crossed. The assessment was completed timely as it was initiated on 4/27/17, and completed on 5/8/2017. The quality of the assessment is discussed in further detail below.
- For Individual #184, the PNMT conducted a timely review and assessment related to GI problems/emesis and aspiration. On 5/29/17, Individual #184's IDT referred him to the PNMT, which was the date on which he returned from the hospital. He had met criteria for emesis (i.e., greater than three in 30 days) with a left lower lobe pneumonia occurring, following an emesis episode on 5/16/17. The assessment process began on 5/29/17, and was completed on 6/14/17.
- Individual #510's IDT did not refer her to the PNMT to address her weight loss over the course of the year. Each quarter, the IDT noted a decrease in weight (7.5%, then 8.5%, and then 9%), but did not make a referral until 1/6/17. Due to the declining nature of her status and its global impact on her ability to function, the PNMT should have completed a full assessment, but did not. The PNMT provided a brief review of her weight and falls only, but this did not meet her needs.
- On 10/26/17, the PNMT initiated a review of Individual #503 in relation to GI issues, but the review was not completed for discussion with the IDT until 1/10/18. Evidence was not found of a Registered Dietician's participation, despite the potential impact of feeding on emesis. The summary of the review did not include monitoring data from direct observations of Individual #503. The summary of the review stated that emesis occurred when the individual was in bed and after feedings, but provided no data to support this conclusion. No review of the head-of-bed elevation was noted in response to emesis in

bed. The PNMT/IDT did not put a plan in place for increased monitoring of positioning. The PNMT recommended alternate positioning for oral case, but not for enteral feeding.

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

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments.

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #284, and Individual #510). The following summarizes some of the concerns noted with the three assessments that the PNMT completed:

- For Individual #199, the PNMT assessment listed medications that had emesis listed as a potential side effect, but provided no further detail about potential side effects that Individual #199 was experiencing. The PNMT assessment also included a statement that stopping the medications could cause vomiting, but did not provide further analysis or clarification. The PNMT assessment identified behavioral issues (e.g., such as refusal to conform with her diet, refusal to follow positioning instructions), but provided no further analysis or input from Behavioral Health Services to address the identified issues. The assessment did not provide a comparative analysis regarding whether noted issues were new or existing. The PNMT concluded that the root cause was the individual's non-compliance with positioning instructions, but the PNMT did not provide data to support this correlation.
- Individual #430's PNMT assessment did not include an eating/mealtime evaluation in response to the aspiration pneumonia incident, but rather referenced an eating evaluation from 2016. The PNMT also should have completed an observation of him during mealtime to assess his limited range of motion due to the shoulder fracture. The PNMT concluded that the root cause of the fall was the seizure, and recommended further work-up of the seizures.
- For Individual #184, the PNMT concluded that supports were effective, but given that the emesis was still occurring, the data did not support this statement. The root cause analysis focused on the occurrence of emesis due to his stomach being full, but lacked data regarding residuals. The assessment did not include evidence that the PNMT addressed issues with positioning compliance. More specifically, according to an ISPA, dated 12/6/17, staff working with Individual #184 failed to implement his PNMP positioning instructions during 12 of 17 observations. Based on review of the documentation provided, no evidence was found to show that the PNMT or IDT developed any plan to address the lack of compliance. Given his ongoing problems with emesis, this was a significant concern.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: It was good to see that the PNMPs/Dining Plans for all nine individuals reviewed met criteria and addressed the individuals' specific needs. Overall, though, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429

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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	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.	39% 7/18	0/2	2/2	0/2	0/2	1/2	2/2	2/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	27% 4/15	0/1	0/1	1/2	0/1	0/2	2/2	1/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	22% 4/18	1/2	0/2	1/2	2/2	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: choking, and falls for Individual #248; GI problems, and aspiration for Individual #199; weight, and falls for Individual #284; weight, and fractures for Individual #430; aspiration, and GI problems for Individual #184; choking, and falls for Individual #300; weight, and falls for Individual #510; aspiration, and GI problems for Individual #503; and aspiration, and GI problems for Individual #429.

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

c. All individuals reviewed had PNMPs and/or Dining Plans. It was good to see that all nine met criteria.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for GI problems, and aspiration for Individual #199; GI problems for Individual #184; choking, and falls for Individual #300; and weight, and falls for Individual #510.

f. The IHCPs that identified triggers and actions to take should they occur were those for falls for Individual #284; choking, and falls for Individual #300; weight for Individual #510.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring. The exceptions were for choking for Individual #248; falls for Individual #284; and weight, and fractures for Individual #430.

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	248	199	284	430	184	300	510	503	429
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	100% 3/3	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1	1/1
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1					N/A			0/1	N/A
Comments: a. It was positive that for the three individuals reviewed with enteral nutrition that their IRRFs and/or OT/PT assessments provided clinical justification for the continued medical necessity. b. Individual #503's IDT determined that attempts to return to oral intake should be put on hold until the emesis decreased, but offered no plan to address the emesis.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Often, OTs/PTs did not complete timely assessments or consultations to address individuals' changing needs. The quality of OT/PT assessments continues to be an area on which Center staff should focus as well. Often, they included incomplete information and analyses, did not offer recommendations to address individuals' needs, and at times, appeared to show an acceptance for individuals' declines as opposed to recommending ways to enhance individuals' independence. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
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% 5/9	0/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	44% 4/9	0/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	N/A	N/A	0/1

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

- No assessment was found in response to Individual #248's falls. The OT/PT did not provide a consultation outside of doing a dressing assessment, which only focused on balance when dressing and did not address the other circumstances around which the falls occurred.
- For Individual #284's falls that occurred between April 2017 and August 2017, when the threshold was met for referral to PNMT, no OT/PT assessment or consult was found. A PNMT note, dated 6/22/17, included a fall discussion that theorized that

many of the falls were drops. However, this note lacked evidence of a balance assessment or a comprehensive falls assessment.

- The OT/PT did not provide an assessment in response to Individual #300's fall and fracture (i.e., acute burst fracture to L3/spine). While the OT/PT did complete a consult, it did not include an assessment of balance, which was noted as the cause of the fall. The root cause analysis was incomplete in that it ended with the fall and not what caused the fall. Individual #300's previous falls were attributed to a loss of balance as well, so this warranted review.
- Individual #510's last comprehensive OT/PT assessment was completed in 2012. Due to the progressive nature of her illness, an updated comprehensive assessment was warranted.
- The last comprehensive assessment for Individual #503 was dated 2014. In March 2016, she returned to the Center after a failed community placement, but the OT/PT did not complete a comprehensive assessment at that time. In addition, according to her 6/5/17 update, the OT recommended further sensory assessment. However, no sensory consultation was found.

d. Individual #510 and Individual #503 should have had updated comprehensive assessments, but, as discussed above, they did not.

e. The following provides some examples of concerns noted with regard to the required components of OT/PT assessments reviewed:

- 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: Most assessments reviewed met this criterion. However, Individual #199's update stated that she remained functionally unchanged, but then followed that statement with a description of multiple illnesses and a description of a decline;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: Most assessments reviewed met this criterion. However, Individual #199's update listed her health risks, but did not review or analyze information related to the level of risk. Rather, the assessors deferred this to discussion at the ISP meeting;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: Most assessments reviewed met this criterion. However, Individual #199's and Individual #430's updates listed the medications and their potential impact, but provided limited to no discussion of the impact of medications on OT/PT supports, and/or failed to identify whether or not the individual experienced potential side effects;
- 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: Most updates reviewed did not meet this criterion. Many updates provided a limited description of fine motor, gross motor, and sensory skills, and activities of daily living. In some instances, the updates stated "no changes" without summarizing the individuals' 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): Most assessments reviewed met this criterion. However, Individual #199's update did not. It only listed her adaptive equipment;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: The majority of assessments did not meet this criterion. They lacked comparative analysis, sometimes stating that no changes occurred without providing a description of the individual's baseline, and did not analyze current functioning (e.g., increases in falls);
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: None of the updates reviewed met this criterion. Often, assessors concluded that supports were effective

without providing monitoring or other 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 did not include evidence regarding progress, maintenance, or regression. Even when formal PT services were provided (e.g., Individual #184), the assessments did not include clear results. In other instances, justification was not provided for not developing OT/PT supports to address identified needs (e.g., Individual #199's inability to achieve full right knee extension, Individual #248's falls, Individual #300's issues with balance); 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: As noted above, updates often did not offer recommendations to address individuals' needs, and at times, appeared to show an acceptance for individuals' declines as opposed to recommending ways to enhance individuals' independence.

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

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

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 IDTs were reviewing and making changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually. However, ISPs need to summarize individuals' gross and fine motor skills, activities of daily living abilities and needs, and ambulation skills, as well as reflect strategies, interventions and programs from the OT/PT assessments. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 248	199	284	430	184	300	510	503	429
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	64% 7/11	1/1	0/3	1/1	0/1	1/1	1/1	1/1	1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/4	N/A	0/3	N/A	0/1	N/A	N/A	N/A	N/A	N/A

Comments: a. ISPs reviewed lacked a summary of individuals' gross and fine motor skills, activities of daily living abilities and needs, and ambulation skills. b. It was positive to see that individuals' PNMPs were updated throughout the year through ISPA meetings for significant changes, or in ISP monthly reviews for minor changes. c. and d. Individual #199 and Individual #430's IDTs did not include formal therapy goals/objectives and programs in ISPs or incorporate them through ISPAs.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: With a few exceptions, communication assessments generally were completed timely. If the Center maintains its performance in this regard, after the time of the next review, Indicator a.iii might move to the category of less oversight. However, the quality of communication comprehensive assessments and updates needed significant improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following:	N/A									

	• 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.										

d.	Individual receives quality Comprehensive Assessment.	0% 0/4	0/1	N/A	0/1	N/A	N/A	N/A	0/1	0/1	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/5	N/A	0/1	N/A	0/1	0/1	0/1	N/A	N/A	0/1

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

- Individual #248's last comprehensive assessment was completed in 2013. Since then, he experienced declines in receptive and expressive language. These changes of status should have triggered the completion of a comprehensive assessment, but the SLP conducted only an update. The update did not identify the underlying cause of the declines.
- The SLP did not provide justification for not completing a comprehensive assessment when Individual #503 returned from a failed community placement.

d. As noted above, Individual #248 should have had a comprehensive communication assessment completed, but did not. The following describes some of the concerns with the three assessments reviewed:

- The individual's preferences and strengths are used in the development of communication supports and services: The SLP did not expand upon Individual #510's strengths with regard to using signs and communication cards (e.g., formal training or use of higher tech devices);
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: Individual #503's assessment primarily focused on existing skills and did not provide an in-depth analysis of the individual's potential for expansion or development of skills;
- The effectiveness of current supports, including monitoring findings: Often, assessors concluded that supports were effective, but provided no data to support this conclusion, including for example, interviews with staff with regard to individuals' Communication Dictionaries;
- 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: All three

assessments provided limited assessment of AAC and EC options, including for example, limited trials, lack of exposure to higher tech devices, and lack of follow-up even when the assessment indicated that further exploration of EC options was warranted; 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: Given that thorough assessments were not completed of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs.

On a positive note, all three assessments provided:

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

e. The following provide examples of concerns noted with regard to the required components of the five communication updates reviewed:

- The individual's preferences and strengths are used in the development of communication supports and services: For two of the updates reviewed, a connection was not found between the individuals' preferences and the recommendations and/or goals/objectives;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Although Individual #199's update listed her medications and the potential impact on speech and cognition, the SLP provided no information about whether or not the individual appeared to be experiencing any of the potential side effects;
- 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: None of the updates reviewed met this criterion. Some of the problems noted included a lack of discussion about ways to expand some individuals' high-level receptive and expressive skills; recognition that the current AAC system was not effective, but no discussion of alternatives; and a lack of carryover of information (e.g., test scores) from the comprehensive assessment to allow comparison from then to the present;
- The effectiveness of current supports, including monitoring findings: None of the updates reviewed met this criterion. The updates did not include monitoring findings, or other data to substantiate the conclusion that supports were effective; and
- 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: For the two individuals for whom this was applicable, the assessment was incomplete, either due to a lack of information from formal testing to determine the individual's strengths and needs, and/or limited trials of few AAC options; 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: Given that thorough assessments were not completed of individuals' communication needs, it was unclear whether or not the assessments

included a full set of recommendations to address individuals' needs.
On a positive note, the updates all sufficiently addressed:
- 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: Given that over the last two review periods and during this review, for the individuals reviewed, ISPs included a description of how the individual communicates, and how staff should communicate with the individual (Round 10 – 89%, Round 11 – 100%, and Round 12– 89%), Indicator a will move to the category requiring less oversight. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	56% 5/9	1/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 10/10	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. Individual #248 experienced declines in receptive and expressive language. Without a comprehensive assessment to explore these declines, it was unclear whether or not the ISP accurately described his current communication skills.

c. As noted above, it was not clear from the assessments reviewed that SLPs had identified all the communication supports that individuals needed.

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: Some SAPs had reliable data, an improvement from previous reviews. On the other hand, fewer SAPs were based on assessments results, or were practical, functional, or meaningful. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
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.	19% 5/26	2/3	1/2	1/3	1/3	0/3	0/3	0/3	0/3	0/3
4	SAPs are practical, functional, and meaningful.	31% 8/26	3/3	1/2	0/3	1/3	1/3	1/3	0/3	0/3	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	42% 11/26	3/3	1/2	0/3	1/3	2/3	0/3	1/3	2/3	1/3

Comments:
3. Five of the 26 SAPs were based on assessments. Exceptions included skills that had been identified as mastered in the individual's functional skills assessment (Individual #423 - request trip; Individual #2 - remote control; Individual #49 - conversation, adaptive switch, joint attention; Individual #561 - personal information; Individual #474 - brush teeth, read social skills; and Individual #248 - street crossing, participate in activity, dress for weather), and skills that had not been assessed through baseline observation (Individual #640 - blood pressure; Individual #199 - scavenger hunt; Individual #2 - mail card; Individual #561 - thread needle, medication; Individual #154 - allow person to sit near him, leave kitchen with his clothing on; and Individual #474 - talk about feelings). Two other programs that received a zero rating on this indicator were Individual #423's taking an order because the current level of performance referenced her bed-making skills, and Individual #154's wearing clothing because he currently had this skill.

4. Eight of the 26 SAPs were considered to be practical, functional, and/or meaningful. In addition to those skills which were identified as mastered in the functional skills assessment, exceptions included the following: (a) SAPs that addressed compliance rather than skill acquisition (e.g., Individual #154 keeping his clothing on; Individual #474 brushing his teeth; and Individual #248 participating in an activity); (b) SAPs that did not address skill development that would help the individual reach his/her identified goal (e.g., Individual #423 learning to play a game when it was her goal to work in the community; and (c) SAPs that addressed activities in which the individual had refused to participate (e.g., Individual #2 - mailing a card).

5. Of the 26 SAPs reviewed, there was evidence that 11 had been monitored for data reliability. It was difficult to determine whether 80% IOA had been achieved because a percentage was not provided. Rather, yes was recorded under IOA documentation.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.											
Summary: Performance maintained for indicators 10 and 11 and decreased for indicator 12. More attention should be paid to ensuring these foundational assessments are completed. Note, however, that all three indicators were met for one individual. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
10	The individual has a current FSA, PSI, and vocational assessment.	67% 6/9	0/1	1/1	1/1	1/1	1/1	0/1	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.	56% 5/9	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1

Comments:
10. Six of the nine individuals (Individual #199, Individual #423, Individual #2, Individual #49, Individual #474, Individual #248) had current assessments. A vocational assessment had not been completed for Individual #640, Individual #561, and Individual #154. Although Individual #640 was enrolled in school, he was at an age when vocational planning should begin. Individual #561 had recently withdrawn from school so vocational planning should be a priority. Lastly, Individual #154 had no scheduled time outside of his home. Even part-time work may be of interest to him.

11. As noted in the individual's QIDP tracking data, assessments were available by the identified due date for five of the nine individuals (Individual #199, Individual #2, Individual #49, Individual #474, Individual #248).

12. The assessments for two individuals included recommendations.

- Individual #423's FSA and vocational assessment included SAP recommendations. It should be noted, however, that several of these recommendations addressed compliance matters and not new skill development.
- Individual #474's FSA included SAP recommendations, while his vocational assessment recommended a tour and situational assessment as he was enrolled in school at the time that this was completed. As he was currently 18 years old, a repeated vocational assessment is recommended.

As noted in the past, the FSA addressed a broad range of skill domains. As such, a comprehensive range of potential skill programs should be identified.

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

This Domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and implementation of plans by the various clinical disciplines. Twenty-eight of these were moved to, or were already in, the category of requiring less oversight after the last review. Presently, three additional indicators will move to the category requiring less oversight. These were in the areas of psychiatry, and dental. One indicator in psychology 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.

<u>Goals/Objectives and Review of Progress</u>
In psychiatry, the content of the quarterly documentation contained the required content except for a discussion of non-pharmacological treatments other than those contained in the PBSP.

In psychiatry, implementation of the side effect assessments was occurring, which was good to see. Some additional attention was needed to ensure timely review by the prescriber.

In behavioral health services, given the absence of good, reliable data, progress could not be determined for all of the individuals.

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, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

<u>Acute Illnesses/Occurrences</u>
Regarding application of crisis intervention restraint more than three times in any rolling 30-day period, for one individual, the IDT met as required, but for the other individual, the IDT did not meet within the required timelines (therefore some indicators could not be scored).

When an individual was deteriorating, or was having worsening psychiatric condition, actions were taken by the psychiatrist and IDT, and these actions were implemented.

Based on discussions with State Office, the Center did not submit acute care plans. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, the lack of acute care plans consistent with relevant nursing standards for all acute issues/occurrences is a substantial deviation from standard practice and needs to be corrected.

For acute issues addressed at the Center, additional work was needed to ensure that PCPs or other providers assessed the issues according to accepted clinical practice and conducted necessary follow-up. It was positive that overall, individuals reviewed requiring hospitalizations, ED visits, or Infirmary admissions received timely and quality evaluations by the PCP or a provider prior to the transfer, as well as upon their return. In addition, for individuals reviewed who were transferred to the hospital, a PCP or nurse communicated necessary clinical information with hospital staff.

For the dental emergency reviewed, the Dental Department provided timely dental treatment, and the PCP provided pain management.

Implementation of Plans

Pretreatment sedation and physical restraint were in the plan for dental issues for some individuals. The Center is advised to review the risk-benefit of this intrusive form of restraint and to consider a more focused approach to desensitization plans.

For more than two-thirds of individuals reviewed, there was evidence that over 80% of their assigned staff had been trained on their PBSPs. The Behavioral Health Services Department continued to employ behavior coaches who could provide assistance during behavioral crises seven days a week, 24 hours per day.

For about two-thirds of individuals reviewed, corrective actions had been recommended when there was no progress in PBSPs. Implementation was evident for most of these. A Root Cause Analysis completed in November 2017 recommended revising Individual #199's PBSP to include reinforcement for medication compliance, however, this was not evident in the plan that was updated in February 2018.

It was good to see that data were presented by behavioral health services staff in clinical meetings. Graphic summaries of PBSP target behaviors, however, were not adequate and did not include enough relevant information to make them useful for understanding the graph and the trend line. Similarly, it was good to see that individuals were reviewed by peer review, however, when peer review made recommendations, there was usually no evidence that those recommendations were implemented.

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.

Significant work is needed to ensure that individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. Of significant concern, for the 18 risk areas reviewed for the nine individuals, IDTs had assigned only one action step to a PCP.

PCPs need to review consultations in a timelier manner. Overall, though, PCPs generally wrote IPNs that provided necessary information about the consultations reviewed, and ordered agreed-upon recommendations.

On a positive note, for the nine individuals reviewed, medical practitioners 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.

It was good to see that the individuals reviewed received the dental treatment they needed, such as prophylactic care, tooth brushing instruction, fluoride treatment, and emergency dental treatment. Due to sustained performance, two indicators in relation to prophylactic care and tooth brushing instruction will move to the category of less oversight. Work is needed, however, to ensure that individuals who need suction tooth brushing have related action steps in their ISPs, staff implement the tooth brushing as required, and the Dental Department conducts monitoring of the quality of the technique.

Continued improvement was noted with regard to the quality of the Quarterly Drug Regimen Reviews (QDRRs). It was also positive that when prescribers agreed to the Clinical Pharmacist's recommendations for the individuals reviewed, documentation was presented to show they implemented them.

Proper fit of adaptive equipment was sometimes still an issue.

Based on observations, there were still numerous instances (62% of 40 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: For one individual, the IDT met as required, but for the other individual, the IDT did not meet within the required timelines (therefore some indicators could not be scored). Overall, performance improved for some indicators and declined for others. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	423	474							
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	50% 1/2	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.	50% 1/2	0/1	1/1							
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/1	N/A	0/1							
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/1	N/A	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?	100% 1/1	N/A	1/1							
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	100% 1/1	N/A	1/1							

24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 2/2									
26	The PBSP was complete.	N/A									
27	The crisis intervention plan was complete.	100% 2/2									
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.	0% 0/2									
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. Two individuals had been restrained more than three times in a rolling 30-day period during the six months prior to the onsite visit. For Individual #474, there was evidence that his IDT met within 10 days of the fourth restraint that occurred between 8/10/17 and 8/20/17. There was no evidence that the IDT for Individual #423 met following her fourth restraint between 10/28/17 and 11/1/17.

20. During the review, it was noted that phone calls with his mother could be distressful to Individual #474. Staff were assigned to monitor these calls to ensure that the conversation remained appropriate and not upsetting to Individual #474. Individual #474's medications were also reviewed. It was concerning that the minutes noted that "staff are encouraged to ask Individual #474 if he wants his additional medication." This appears to contradict his PBSP, which indicated that "home staff cannot suggest or tell Individual #474 to ask for medication." The IDT is advised to resolve this matter and ensure that everyone understands acceptable practice. Regarding his adaptive skills, Individual #474 was awaiting an assessment by the Texas Work Commission. It was unclear what action has been taken to expedite this assessment. One area that was discussed repeatedly was Individual #474's move from one home to another when he turned 18 years of age. He had been living with five other school-age boys where each had his own bedroom. On his birthday, Individual #474 moved to a home with 17 other men, ages 17 to 72. It was noted that he no longer had peers with common interests with whom he could play and interact. No action plans were identified to address this issue.

21. Refusals to engage in activities had been reinforced as Individual #474 was allowed to sleep for long periods of time while at school. There was no plan to address this issue even though he would soon be starting school again. Although it was noted that Individual #474 had begun working on campus and this was considered a "new and valued activity," he would refuse to attend. Staff are advised to complete a new vocational assessment to determine his interests and strengths.

22. Immediate antecedents included Individual #474 seeking attention and/or access to tangible items. Both of these matters were addressed in his PBSP that was revised in September 2017 and November 2017.

23. Consequent events included the reaction of others in the environment. Both housemates and staff had been reported as being fearful of Individual #474. To help mitigate this issue, behavior coaches were assigned to the home to help support everyone present. Continued efforts to expand his activities of interest off the home and in the community should remain the focus of the IDT.

25-27. Both Individual #423 and Individual #474 had current Positive Behavior Support Plans (PBSP) and Crisis Intervention Plans (CIP). Review of their PBSPs can be found in the Psychology/Behavioral Health sections of this report. It was determined that their CIPs were complete.

28. Although treatment integrity was assessed regularly, the PBSPs for both Individual #423 and Individual #474 indicated that staff competency could be assessed via verbal and/or written comprehension. It is essential that observation of staff occur to ensure the integrity of PBSP implementation.

29. There was evidence that Individual #474's PBSP was reviewed and revised, with the latest revision occurring in November 2017. Although Individual #423's plan was dated November 2017, there was no indication that this had been reviewed as a result of her repeated restraints.

Additional comments:
Four of the nine individuals (Individual #640, Individual #2, Individual #49, Individual #248) a Medical Restraint Plan. Pretreatment sedation was indicated for medical issues for Individual #640, Individual #2, and Individual #248. Pretreatment sedation and physical restraint were indicated for dental issues for Individual #49 and Individual #248. For both individuals, the MRP indicated that their wrists and heads could be stabilized to ensure dental care. The facility is advised to review the risk-benefit of this intrusive form of restraint and to consider a more focused approach to desensitization plans.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: One individual in the review group was not receiving psychiatric services, however, a Reiss was implemented in 2016 due to status changes. Indicator 2 will be moved to the category of less oversight. Indicator 3 will remain in active monitoring for possible review at the next onsite visit.			Individuals:								
#	Indicator	Overall Score	503								
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.	100% 1/1	1/1								

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								
Comments:											

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: As noted for outcome 2, good progress was occurring in the creation of psychiatry-related goals. Once more complete, progress can be determined and indicators 8 and 9 can be scored. Even so, when an individual was deteriorating or was having worsening psychiatric condition, actions were taken by the psychiatrist and IDT, and these actions were implemented. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
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	1/1	1/1	N/A	1/1	N/A	1/1	N/A
11	Activity and/or revisions to treatment were implemented.	100% 5/5	N/A	1/1	1/1	1/1	N/A	1/1	N/A	1/1	N/A

Comments:

8-9. Without measurable goals and objectives that met criteria for indicators 4-7, progress could not be determined. Thus, the first two indicators are scored at 0%.

10. Although deficiencies in the data collection made it impossible to determine if progress was being made on the goals, the review of 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 #199, Individual #423, Individual #2, Individual #561, and Individual #474.

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: Performance was maintained since the last review; most but not all PBSPs showed psychiatrist participation. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
24	The psychiatrist participated in the development of the PBSP.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
Comments: 24. The documentation of the psychiatrist's participation in the development of the individual's behavioral plan was found in either the Joint Case Formulation documentation or the Formulation and Integration of Treatment (FIT) for all individuals, except Individual #640 and Individual #154.											

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: The inclusion of discussion of non-pharmacological treatments is needed in order for indicator 34 to be scored as meeting criteria. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248

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.	33% 3/9	1/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1
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 contained the required content for three of the individuals. The deficits in the documentation for Individual #199, Individual #2, Individual #561, Individual #154, Individual #474, and Individual #248 were all related to the lack of discussion of non-pharmacological treatments other than those contained in the PBSP.											

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: Implementation of these side effect assessments was occurring, which was good to see. Some additional attention is needed to ensure timely review by the prescriber. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1
Comments: 36. Review of the data indicated that the monitoring for side effects with the MOSES and AIMS was completed for each individual as per the required schedule, which was good to see, but the requirement for timely review by the prescriber was not met for Individual #49 and Individual #154. During the Center's QAQI meeting during the onsite week, the lead psychiatrist reviewed the department's internal data that identified a weakness in the timely review of the MOSES and AIMS as well as the plan to correct this.											

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	640	199	423	2	49	561	154	474	248
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: 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 remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	71% 5/7	N/A	1/1	1/1	0/1	1/1	1/1	0/1	1/1	N/A
9	Activity and/or revisions to treatment were implemented.	57% 4/7	N/A	0/1	1/1	0/1	1/1	1/1	0/1	1/1	N/A

Comments:

6. Although graphs included in the progress notes suggested improving behavior for Individual #640, Individual #49, and Individual #248, this indicator was rated as zero due to problems with data reliability. Graphs indicated a lack of progress for Individual #199, Individual #2, Individual #561, Individual #154, and Individual #474. Although graphs reflected recent improvement for Individual #423, the use of restraint had increased.

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

8. For five of seven individuals, corrective actions had been recommended. This included Individual #199, Individual #423, Individual #49, Individual #561, and Individual #474. For Individual #2 and Individual #154, there was no evidence of recommended action due to lack of progress.

9. There was evidence that revisions had been made to the PBSPs for Individual #423 (tokens replaced with level system), Individual #49 (revised when he was not making progress earlier in the fall), Individual #561 (revisions presented at Behavior Support Committee meeting held during the onsite visit), and Individual #474 (changes in reinforcers, additional activities at day program, and behavior coaches assigned to his home).

Although a Root Cause Analysis completed in November 2017 recommended revising Individual #199's PBSP to include reinforcement for medication compliance, this was not evident in the plan that was updated in February 2018.

As discussed at the BSC meeting, staff are advised to strengthen the reinforcement component of Individual #561's PBSP. He experienced multiple changes over the past several months and will likely need changes to his schedule since withdrawing from school, and increased motivation to participate in programming and behave in a socially appropriate manner. As a response cost component was added to his plan, it is particularly important to ensure that he continues to earn more points than he loses.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: Performance improved since the last review, and with sustained high performance, this indicator might be moved to the category of requiring less oversight after the nest review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
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.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.										

Comments:

16. For seven of nine individuals, there was evidence that over 80% of their assigned staff had been trained on their PBSPs. The exceptions were Individual #49 (73%) and Individual #474 (78%). It was commendable that behavioral health services staff noted specifically when the home supervisor, night supervisor, and activity specialist had received training. Although the names of activity center or work site staff were not provided, there was evidence that staff from one or both of these settings had been trained on the PBSP for Individual #199, Individual #423, Individual #49, Individual #561, Individual #154, Individual #474, and Individual #248.

Behavioral health services staff were completing repeated direct observations of some individuals throughout the year. This should be standard practice for all individuals.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.	
Summary: It was good to see that data were presented by behavioral health services staff in clinical meetings (indicator 21). Graphic summaries of PBSP target behaviors were not adequate and did not include enough relevant information to make them useful for understanding the graph and the trend line (indicator 20). These two indicators will remain in active monitoring. It was good to see that individuals were reviewed by peer review. When peer review made recommendations, however, there was usually no evidence that those recommendations were implemented (i.e., implementation was evident in one of	Individuals:

five cases, i.e., 20%). As a result, indicator 22 will be returned to active monitoring.

#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
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	0/1	0/1	1/1	1/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 3/3	1/1	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. But due to poor performance in peer review follow-up, indicator 23 will be returned to active monitoring.									
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.										

Comments:
20. Graphs included in the monthly progress notes for Individual #49 and Individual #561 were considered useful for making data based treatment decisions.

Although all graphs were simple and easy to interpret, for most individuals, phase change lines were missing.

- For example, graphs for Individual #640, Individual #2, Individual #154, and Individual #474 did not indicate the introduction of the PBSP or revised PBSP.
- Similarly, the change from a token system to a level system was not indicated on the graphs for Individual #199 or Individual #423.
- Individual concerns include no documentation of Individual #423's withdrawal from work, Individual #154's head injuries, or Individual #561's withdrawal from school.

All of these events are variables to consider when assessing progress.

Moreover, in some cases, the vertical axis was not labeled appropriately. Graphs for Individual #199 and Individual #248 were labeled as frequency, but information in the PBSP suggested that behavioral episodes were recorded.

21. An observation was conducted in the psychiatric clinic for three individuals, Individual #640, Individual #49, and Individual #561. The BCBA or behavior health specialist reviewed the data including measures collected for the current month. As has been recommended previously, it would be helpful to have hard copies of the graphs so that all present can review the visuals display for trends, events that impacted targeted behaviors, etc.

22. There was evidence that eight of the nine individuals had been reviewed in either external peer review and/or internal peer review (all except Individual #248). For three of these individuals, the minutes did not include any recommendations (Individual #640, Individual #199, Individual #2).

For the other five, there was evidence that the word "intention" had been removed from the operational definitions for aggression and self-injury in Individual #561's PBSP.

For four others, evidence was not found of revisions to their PBSPs. It was recommended that Individual #423's replacement behavior be changed to engaging in activities on the home and have staff switch every two hours rather than every four hours. There was no evidence that recommendations following an observation by the occupational therapist were included in Individual #49's PBSP. Recommendations made following a meeting of the internal peer review committee in January 2018 were not found in Individual #154's PBSP. Finally, there was no evidence of a script developed to help Individual #474 when calling his family.

Outcome 8 – Data are collected correctly and reliably.

Summary: Performance was about the same as last time. An adequate, reliable data collection system is required (also see indicator 5). These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 640	199	423	2	49	561	154	474	248
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.	22% 2/9	1/1	0/1	0/1	1/1	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).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
26-27. Due to the concerns regarding data timeliness, it was determined that the data systems used to measure target and replacement behaviors identified in the PBSPs were not adequate.

28. Data timeliness measures were computer-generated indicators of data recorded every two hours. IOA was assessed via observation or videotape review. Treatment integrity was assessed via verbal or written report and/or observation.

The PBSPs for five of the nine individuals (Individual #199, Individual #423, Individual #561, Individual #474, Individual #248) indicated that the prevention, responding, and documentation sections of the PBSP would be assessed via verbal or written comprehension. Only the replacement behavior was to be observed. The PBSP for Individual #49 noted that all elements of the plan would be assessed via verbal or written comprehension, while the PBSP for Individual #154 noted retraining would occur if staff performed at less than 80% when interviewed. While all individuals had acceptable measures of data timeliness and IOA, only Individual #640 and Individual #2 had acceptable measures of treatment integrity, i.e., direct observation.

29. As noted above, data timeliness was assessed via computer-generated reports. IOA and treatment integrity was to be assessed monthly for Individual #640, Individual #199, Individual #2, Individual #154, and Individual #474. After two months of weekly assessments, Individual #248's plan was also to be assessed monthly. Assessments were to be completed weekly for Individual #561, bi-weekly for Individual #423, and quarterly for Individual #49. All measures were expected to be 80% or better.

A request was made by the Monitoring Team for the most recently completed forms used to assess IOA and treatment integrity. Staff record Planned Activity Checks, integrity/reliability measures, interview scores, and core competency knowledge probes. The section for IOA and treatment integrity had four columns: behavior, trainer, staff, and implemented PBSP correctly (Y, N, or N/A). When reviewing the completed forms, it was not possible to discern what components of the PBSP were observed.

Of the 32 completed forms, 18 referenced at least one targeted problem behavior, 13 referenced replacement behavior, and one indicated that neither of these had been observed. In every case, numbers were provided under trainer and staff and then either yes, no, or not applicable was listed in the last column. This appeared to be related to agreement regarding the occurrence/nonoccurrence of the identified behavior, but did not indicate any assessment of fidelity of plan implementation.

30. In no case did data timeliness measures meet the established level of 80% or better. However, IOA and treatment integrity measures were achieved for six of the nine individuals (Individual #640, Individual #199, Individual #423, Individual #2, Individual #561, Individual #474).

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to	6%	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2

	measure the efficacy of interventions.	1/18									
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 #248 – cardiac disease, and other: pica; Individual #199 – cardiac disease, and GI problems; Individual #284 – constipation/bowel obstruction, and falls; Individual #430 – fractures, and seizures; Individual #184 – GI problems, and other: urological obstruction; Individual #300 – fractures, and constipation/bowel obstruction; Individual #510 – seizures, and weight; Individual #503 – respiratory compromise, and GI problems; and Individual #429 – respiratory compromise, and osteoporosis).

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 #300 – constipation/bowel obstruction.

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

Outcome 4 – Individuals receive preventative care.

Summary: Eight 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.

#	Indicator	Overall Score	Individuals: 248	199	284	430	184	300	510	503	429
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	N/A	N/A	1/1	1/1	N/A	1/1	1/1
	iii. Breast cancer screening	75% 3/4	N/A	1/1	0/1	N/A	N/A	1/1	N/A	1/1	N/A

	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
Comments: a. Overall, the individuals reviewed generally received timely preventive care, which was good to see. The exception was that Individual #284's last mammogram was completed on 10/25/16. On 12/8/17, another attempt was made, but was unsuccessful. In the past, she was sedated with 2 mg of Ativan. The plan was for the IDT to meet with the guardian.											

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	50% 1/2	N/A	N/A	N/A	N/A	0/1	N/A	1/1	N/A	N/A
Comments: a. Individual #510 met criteria. Her annual medical assessment contained a detailed explanation of her progressive dementia with severe anorexia. On 2/2/17, she had a palliative care consultation, and hospice also provided a consultation. The DNR for Individual #184, dated 2/22/17, listed respiratory fragility and recurrent aspiration pneumonia as the irreversible qualifying condition. However, the evaluation and treatment the Center had provided for his recurrent aspiration pneumonia was incomplete.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.	
Summary: For acute issues addressed at the Center, additional work was needed to ensure that PCPs or other providers assessed the issues according to accepted clinical practice and conducted necessary follow-up. It was positive that overall, individuals reviewed requiring hospitalizations, ED visits, or Infirmary admissions	Individuals:

received timely and quality evaluations by the PCP or a provider prior to the transfer, as well as upon their return. In addition, for individuals reviewed who were transferred to the hospital, a PCP or nurse communicated necessary clinical information with hospital staff. If the Center sustains its performance in this area, Indicator f might move to the category of less oversight at the time of the next review. Because of the importance of acute care, the remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
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.	75% 12/16	1/2	2/2	2/2	N/A	2/2	2/2	1/2	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.	73% 8/11	0/1	1/1	1/1		2/2	2/2	1/1	1/1	0/2
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <u>or</u> 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	1/1	2/2	1/1	1/1	1/1	1/1	2/2	N/A	2/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	86% 6/7	N/A	2/2	0/1	1/1	1/1	1/1	N/A		1/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance 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.	100% 6/6	1/1	N/A	N/A	N/A	N/A	1/1	2/2		2/2
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	67% 2/3	N/A	N/A	N/A	N/A	N/A	1/1	N/A		1/2
h.	Upon the individual's return to the Facility, there is evidence the PCP	100%	1/1	2/2	1/1	1/1	1/1	1/1	2/2		2/2

	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.	11/11									

Comments: a. For eight of the nine individuals reviewed, the Monitoring Team reviewed 16 acute illnesses addressed at the Center, including: Individual #248 (right thumb bruise on 7/14/17, and emesis on 10/31/17), Individual #199 (emesis on 9/21/17, and cellulitis of scalp on 7/31/17), Individual #284 (ulcer of left lip on 8/7/17, and fall with lip injury on 8/25/17), Individual #184 (nausea on 7/13/17, and pruritus of scalp on 8/8/17), Individual #300 [fall with injuries on 10/4/17, and urinary tract infection (UTI) on 12/5/17], Individual #510 (fall with injury on 8/13/17, and rash on feet on 8/15/17), Individual #503 (pressure ulcer near G-Tube on 7/21/17, and emesis on 10/16/17), and Individual #429 (ceruminosis on 8/11/17, and bruise on finger on 8/12/17).

PCPs did not assess the following acute issues according to accepted clinical practice: Individual #248 (emesis on 10/31/17), Individual #510 (rash on feet on 8/15/17), Individual #503 (emesis on 10/16/17), and Individual #429 (bruise on finger on 8/12/17).

b. PCPs did not conduct 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 for the following: Individual #248 (emesis on 10/31/17), and Individual #429 (ceruminosis on 8/11/17, and bruise on finger on 8/12/17).

The following provide examples of concerns noted:

- An on-call PCP IPN, dated 10/31/17 at 5:00 a.m., noted that Individual #248 had a moderate emesis mucous in nature. His vital signs were stable. He had a history of self-induced emesis when agitated and he was agitated at that time. The PCP instructed staff to proceed with oral intake. The PCP did not document in the note if the nurse completed an abdominal exam, or, if so, the results. The Center did not submit a follow-up PCP note, and none of the nursing IPN entries for this date provided any information about emesis.
- With regard to Individual #503's emesis on 10/16/17, the PCP documentation did not include a definitive or differential diagnosis that clinically fit the corresponding evaluation.
- On 8/11/17, Individual #429's PCP diagnosed her with impacted cerumen. The treatment was Debrox three times a day for three weeks. The plan was to reexamine Individual #429 and make a referral for irrigation, if she still had excess wax in her ears. On 9/1/17, the PCP's notes indicated Individual #429 had completed the three weeks of Debrox, and still had impacted cerumen. The PCP prescribed Debrox three times a day for 12 weeks, with follow-up planned on 11/27/17. Based on documentation provided, the follow-up did not occur.
- On 8/12/17, Individual #429 sustained a contusion/sprain of her fourth finger. The PCP did not order any treatment, and noted that the individual had poor tolerance for a splint or ice. The plan was to follow-up in three days. Based on documentation provided, the follow-up did not occur.

c. d., f. through h. For eight of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses/occurrences that required hospitalization, Infirmary admission, or an ED visit, including those for Individual #248 (ED visit for laceration on 12/21/17), Individual #199 (Infirmary admission for emesis on 8/29/17, and Infirmary admission for hypoxia on 11/4/17), Individual #284 (Infirmary admission for cellulitis on back on 10/28/17), Individual #430 (Infirmary admission for rash on 12/18/17), Individual #184 (Infirmary admission for aspiration pneumonia on 10/30/17), Individual #300 (hospitalization for lethargy on 10/10/17), Individual

#510 (ED visit for head laceration and hematoma on 7/23/17, and ED visit for low respirations and bradycardia on 12/3/17), and Individual #429 for post-operative infection on 10/31/17, and bowel obstruction on 11/22/17).

It was positive that overall, individuals reviewed requiring hospitalizations, ED visits, or Infirmary admissions received timely and quality evaluations by the PCP or a provider prior to the transfer, as well as upon their return. In addition, for individuals reviewed who were transferred to the hospital, a PCP or nurse communicated necessary clinical information with hospital staff.

For Individual #429's bowel obstruction on 11/22/17, no ISPA was submitted.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: PCPs need to review consultations in a timelier manner. Overall, though, PCPs generally wrote IPNs that provided necessary information about the consultations reviewed, and ordered agreed-upon recommendations. Although these indicators will all remain in active oversight, with sustained progress, Indicators c and d might move to the category of less oversight at the time of the next review.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.	57% 8/14	0/2	N/A	2/2	2/2	1/2	1/2	N/A	1/2	1/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	100% 14/14	2/2		2/2	2/2	2/2	2/2		2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	93% 13/14	1/2		2/2	2/2	2/2	2/2		2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	67% 2/3	N/A		N/A	N/A	1/1	N/A		N/A	1/2

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 14 consultations. The consultations reviewed included those for Individual #248 for podiatry on 11/21/17, and ophthalmology on 12/27/17; Individual #284 for ophthalmology on 7/19/17, and wound care on 11/1/17; Individual #430 for orthopedics on 7/17/17, and neurology on 9/11/17; Individual #184 for neurology on 8/23/17, and urology on 9/1/17; Individual #300 for orthopedics on 11/1/17, and podiatry on 7/25/17; Individual #503 for podiatry on 9/19/17, and podiatry on 1/16/18; and Individual #429 for neurology on 9/12/17, and neurosurgery on 10/2/17.

b. The reviews that did not occur timely were for Individual #248 for podiatry on 11/21/17, and ophthalmology on 12/27/17; Individual #184 for neurology on 8/23/17; Individual #300 for orthopedics on 11/1/17; Individual #503 for podiatry on 9/19/17; and Individual #429 for neurosurgery on 10/2/17.

c. It was good to see that 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, with the exception of the following: Individual #248's ophthalmologist recommended return in one year, but the PCP's IPN stated that follow-up would occur in two years.

e. For Individual #429, the IDT did not hold an ISPA meeting after the neurosurgeon replaced her vagus nerve stimulator (VNS). The next ISPA, dated 11/16/17, addressed her hospitalization due to the infected surgical site.

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

Summary: For a number of individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were not completed, and the PCPs had not identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 248	199	284	430	184	300	510	503	429
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	1/2	1/2	0/2	2/2	2/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #248 – cardiac disease, and other: pica; Individual #199 – cardiac disease, and GI problems; Individual #284 – constipation/bowel obstruction, and falls; Individual #430 – fractures, and seizures; Individual #184 – GI problems, and other: urological obstruction; Individual #300 – fractures, and constipation/bowel obstruction; Individual #510 – seizures, and weight; Individual #503 – respiratory compromise, and GI problems; and Individual #429 – respiratory compromise, and osteoporosis).

a. It was positive that for the following individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent

with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #248 – other: pica; Individual #284 – constipation/bowel obstruction; Individual #430 – seizures; Individual #184 – other: urological obstruction; Individual #510 – seizures, and weight; and Individual #503 – respiratory compromise, and GI problems. The following provide examples of concerns noted:

- Individual #199 had a history of chest pain. Risk factors for cardiac disease included a history of coronary artery disease, a history of prior nicotine habit, dyslipidemia, obesity, and hypothyroidism. On 4/1/13, 1/5/15, 12/11/16, 1/25/17, and 4/7/17, she complained of chest pain. In the ED and during hospitalizations, she had normal troponin levels, and unremarkable electrocardiograms (EKGs), and echocardiograms indicating normal ejection fraction (i.e., 7/3/16 and 11/17/16). A subsequent final diagnosis was repeatedly atypical chest pain. Her current AMA stated she had a right carotid endarterectomy in the past, but when the Monitoring Team requested evidence of this procedure, the submitted information did not indicate this procedure had been done in the past. On 12/13/16, she did undergo a carotid Doppler, which only indicated bilateral stenosis of 35 to 50%. A computed tomography angiography (CTA) of the chest indicated a large hiatal hernia. On 3/9/17, she saw the cardiologist and was to follow up as-needed. Her most recent lipid panel indicated control of her hyperlipidemia.

  The PCP requested that the IDT develop a plan to treat her repeated atypical chest pain. The plan developed included RN assessment, including vital signs. If the physical findings and vital signs indicated stability, then transfer to the ED was not considered.

  She also had a long history of pedal edema for which she was prescribed hydrochlorothiazide and wore Jobst socks. When her edema resolved, the diuretic was discontinued. However, this was followed within a month by bilateral pedal edema and the diuretic was resumed. On 10/19/17, a left lower extremity Doppler was completed due to left thigh pain, but did not indicate pathology. On 10/19/17, the PCP made a notation to consider a lymphedema clinic, but submitted documentation did not provide evidence this was pursued. She continued to be prescribed medication for her dyslipidemia, pedal edema, hypothyroidism, and anemia. She successfully lost 14 pounds over the year prior to her AMA/IRRF.

  In summary, wrong information (indicating a carotid endarterectomy, when this did not occur) in the AMA was problematic for this individual with complex medical and psychiatric issues. Covering PCPs and consultants are dependent on an accurate history recorded in the AMA. There was no indication in submitted documents that a lymphedema clinic appointment had been completed, or rationale provided for not further pursuing this consideration. Historically, Individual #199 focused on health issues, one of which was chest pain. However, there was no further psychiatric or behavioral health evaluation or identification of the underlying cause of her regular physical complaints.

- Individual #199 also had a history of gastroesophageal reflux disease (GERD), esophageal ulcer, and hiatal hernia, dating back to 2007. In 2009, she underwent a cholecystectomy, and in 2011, had a Nissen fundoplication. In the past, she underwent two ventral hernia repairs. In May 2015, she vomited and developed aspiration pneumonia. She had serial esophagogastroduodenoscopies (EGDs) (i.e., on 3/2/07, 2/18/11, and 9/10/16) confirming esophagitis with ulceration, hiatal hernia, and gastritis. In recent years, she had a long history of vomiting, associated with refusing her medication for GERD, not following positioning instructions, and eating foods that were not part of her-anti reflux diet. The Human Rights Committee

(HRC) approved a restriction to limit access to her personal food, when she was placed on a clear liquid diet due to vomiting. Individual #199 was able to articulate her symptoms, which were consistent with GERD. She continued to have numerous episodes of vomiting (44 episodes in the year prior to the current ISP/IRRF). The most recent vomiting episode in submitted documentation prior to the Monitoring Team visit was 1/10/18. On 10/19/17, a Modified Barium Swallow Study (MBSS) ruled out aspiration and dysphagia. She was medically treated with a proton pump inhibitor, sucralfate, and a pro re nata (PRN, or "as needed) antacid with simethicone.

The status of Individual #199's fundoplication remained unclear. No information was submitted indicating whether this was evaluated to determine if it was functioning or needed revision/rewrapping. No information was provided to determine if a gastric emptying study had been completed/considered as a contributing cause to her significant reflux disease. She had lost desirable weight, but it was concerning whether it was from her GERD/vomiting, volitional/intentional eating less, or a more serious occult disease. Additionally, Behavioral Health Services staff had not been assertive in assisting the IDT to address her noncompliance with needed medical steps under her control.

- In the year prior to the IRRF, dated 8/16/17, Individual #284 had 15 falls. Physical exam indicated that she had increased tone in her plantar flexors and invertors of the right lower extremity with worsening internal rotation. Some of her falls had been associated with injuries. For example, on 9/11/16 and again on 9/13/16, she sustained a chin laceration. On 6/18/17, she dropped to the floor (a challenging behavior) and scratched her left foot. On 6/19/17, she fell in the kitchen on her left hip and hands, but there was no injury. On 6/24/17, she fell in the living room. On 7/24/17, she tripped over a wheelchair and sustained an abrasion to the right elbow. On 8/1/17, she dropped to the floor and injured her lip. On 8/2/17, she slid to the floor and scraped her back. On 8/6/17, she fell while walking in the hall and sustained an abrasion to the left hip. On 8/25/17, she dropped to the ground, and while attempting to arise slipped on wet ground and hit her face, cutting her chin and upper lip. On 8/29/17, she fell from her chair in the kitchen and hit her head on the table while wearing a helmet. On 9/1/17, she slid out of the wheelchair when she was using the restroom and staff had unbuckled her seatbelt; she sustained a cut to her heel. On 9/9/17, she again slid from her chair in the bathroom and scraped the right side of her scalp and forehead. On 9/29/17, she fell in the hallway without injury. On 10/3/17, she was found in the street on the ground with bleeding knees. On 10/15/17, she was pushed by a peer and fell on her back. On 10/28/17, she fell in the living room and later the same day fell in the dining room. On 12/27/17, a peer pushed her and she fell on her right side. On 12/29/17, she fell attempting to get into a wheelchair.

  Individual #284 had been prescribed a helmet and wore knee pads to reduce injuries from falling. Her medical evaluation included ruling out orthostatic hypotension, low blood glucose, dehydration, and cardiac arrhythmias. Despite these areas of review, she continued to fall. Based on the Monitoring Team member's discussion with the PCP, Habilitation Therapy staff evaluated her gait and foot abnormality in 2016, and provided therapy at that time. The PCP was unaware of whether there was ongoing habilitation therapy for her gait abnormality. The PCP did not know whether her footwear at the time of this fall (e.g., slipped on the wet ground) had been checked to determine if the shoes were worn and needed replacement. She had not seen a physiatrist for consideration of further evaluation and treatment of her spasticity (e.g., muscle relaxants, Botox injections, stretching exercise, splints, etc.). Based on the documentation provided, she had not seen a neurologist for her spasticity and abnormality of gait. The PCP was not aware of any involvement from Behavioral Health Services in reducing her intentional dropping to the floor, nor steps taken by the IDT to reduce peer aggression in contributing to her falls.

- Individual #184 had a history of dysphagia with a percutaneous endoscopic gastrostomy tube (PEG-tube) placement in 2007. At that time, he had developed aspiration pneumonia with respiratory failure and required ventilator support. On 10/14/15, he developed aspiration pneumonia, in part due to self-positioning changes in bed at night while tube feeding was administered. Since then, his feedings had been scheduled during the daytime. He had a Mic-Key button and received nutrition through daytime bolus feedings. He continued to have bouts of aspiration pneumonia (i.e., 4/20/16, 8/28/16). He continued to have recreational feeding until 11/10/16, but an MBSS showed silent aspiration with no cough reflex. Since 11/14/16, he has received nothing by mouth (NPO). On 11/22/16, vacuum tooth brushing was started. On 1/1/17 and 2/4/17, he was hospitalized for aspiration pneumonia. On 5/25/17 and 10/30/17, he had large emesis followed by aspiration pneumonia.

  Besides having a history of aspiration pneumonia, Individual #184 also had a history of GERD, dating back to 1995, when he was diagnosed with such using a pH probe. On 6/20/12, an EGD found gastritis, duodenitis, and Barrett's esophagus. As of 10/12/15, his head of bed was elevated 30 degrees. A subsequent EGD found esophageal and pyloric narrowing and these areas were stretched. On 4/17/17, gastroenterology (GI) was again consulted due to recurrent aspiration, and recommended a jejunostomy-tube (J-tube), if the aspirations recurred. On 5/16/17, post-feeding flushes changed from two hours after feeding to one hour after feeding, but this caused increased vomiting, and on 5/25/17, the schedule reverted back to flushes two hours after feeding. A proton pump inhibitor continued to be administered.

  The IDT conducted a root cause analysis, and concluded that his GERD caused the emesis and occurred when he was not maintained in an upright position. On 7/29/17, 8/9/17, and 8/10/17, he again vomited. On 8/11/17, an ultrasound of the gall bladder was completed and was read as normal. The IDT was concerned that he might have induced his vomiting at times, and on 8/22/17, the HRC approved video monitoring for 30 days to determine if his emesis was self-induced. On 9/10/17, he was observed to gag himself by placing his hand in his mouth. The IRRF, dated 1/8/18, indicated Individual #184 had 34 episodes of vomiting during the previous year, compared to six in the prior year. At the time of the Monitoring Team's onsite visit, he had a GI appointment pending on 2/8/18 to rule out GI bleeding, pyloric channel stenosis, and esophageal stenosis.

  As of 2/22/17, Individual #184 had an Out-Of-Hospital Do Not Resuscitate Order (OOH DNR) in place with the qualifying condition listed as recurrent aspiration pneumonia. Although he had EGDs, with findings of GERD and Barrett's disease, there was no gastric emptying study to determine if this was a significant concern, despite the concern of a pyloric channel stenosis. When his flushes were too close, the episodes of emesis increased, also suggesting delayed gastric emptying. However, no gastric emptying study was done to confirm normal motility or indicate the need to review the frequency and rate of formula administration. There was the recommendation for a J-tube in the future, if the reflux and aspiration continued. The PCP had not initiated contact with the GI specialist to discuss whether Individual #184 was a candidate for other surgical (e.g., fundoplication, hiatal hernia repair) or medical options (e.g., H2 blocker, erythromycin, etc.). The results of the video, ordered on 8/22/17 for 30 days or more, were not submitted, and the PCP did not appear to know the results. It was not clear whether or not the video recording had occurred, or if the IDT had analyzed the results. The PNMT had completed bed positioning monitoring in the past, and it showed a continuing need for direct support professional staff training to ensure proper positioning. It would be essential to ensure that prescribed interventions, such as positioning, were consistently implemented in order to justify more aggressive evaluation and treatment. However, it was problematic that Individual #184 had an OOH

DNR in place without thorough evaluation to determine whether or not additional treatment was warranted.

- Individual #300 had a history of a healed fracture to the fifth metatarsal head of the left foot. On 11/20/12, she was noted to have osteoarthritis of her right knee by x-ray. More recently, on 6/5/17, she fell outside by a van. An x-ray of her right knee indicated chronic and degenerative changes. On 8/19/17, she was noted to be not walking normally and complained of pain in her right knee. She wore a knee brace on her right knee. She was noted to have severe genu valgus and retroversion tibial torsion. On 10/4/17, she fell in the bathroom. She subsequently walked into the medication room without any problem. At that time, she denied pain and there was no change in her gait. However, on 10/6/17, she complained of left hip and low back pain and was found to have an L3 compression fracture on x-ray, but it could not be determined if this was a new or old fracture. She also was found to have an age indeterminate left pubic ramus fracture. On 10/6/17, the PCP examined her and found she had a bruise to her left buttocks with discomfort on palpation of the LS spine. On 10/6/17, x-rays indicated multi-level degenerative disk disease of the thoracic spine. On 10/7/17, she had increased pain. Her medication was adjusted and she was prescribed Hydrocodone. She then developed a change in mental status with decreased alertness to verbal and physical stimuli. During this hospitalization, she underwent a magnetic resonance imaging (MRI) of her lumbar spine and an acute burst fracture at L3 was found. The 10/19/17 nursing narrative indicated a night light in her bedroom and bathroom were added and staff were trained on signs of discomfort. On 10/30/17, she was found sitting on the floor holding her elbow. On 11/1/17, the orthopedic consult recommended a lumbosacral corset for a month and to limit bending along with a 10-pound limit to lifting for four to six weeks. She was not considered a candidate for kyphoplasty. On 11/4/17, she was found to have bruising to her outer right calf. On 11/14/17, she received a back brace, but refused to wear it. On 12/1/17, she was walking when a peer bumped into her and she fell and developed a carpet burn, and scrape to the right hand.

  From submitted information, Individual #300 had functional vision. On 1/31/18, the PT completed an assessment of balance. According to this assessment, she required a hand rail to transition from sit to stand, and she did not lose her balance while changing direction or leaning over. She dragged her right foot and wore a knee brace. She reportedly refused use of a walker. The AMA indicated she had a stable gait, and that she had excellent range of motion in all extremities without pain. Muscle strength reportedly was symmetric. She had a mild kyphosis. She was noted to be on Clozapine and Ativan for psychiatric diagnoses, but these were not new medications. She was followed for vitamin D deficiency and osteopenia. She was prescribed alendronate, calcium, and vitamin D supplementation. On 11/18/17, her most recent vitamin D level was in therapeutic range. On 12/14/17, her thyroid function was tested and found to be in the normal range.

  Her frequent falls appeared to be multifactorial. One or more were due to peer interaction, but there was no information regarding how the IDT addressed this concern. She also had osteoarthritis, although the degree to which this caused her discomfort could not be determined from the submitted documentation. It appeared that her arthritic discomfort was intermittent. Some of her injuries and presumed falls were unwitnessed, indicating the need for improved surveillance to determine cause. Although her balance and strength appeared adequate, it was not clear if a formal exercise program had been implemented in her daily routine to improve/maintain her conditioning and prevent worsening of osteopenia. Pain management needed to be reviewed, as she was hospitalized with a primary diagnosis of adverse effect (decreased level of consciousness) to Norco, yet this was not added to the list of allergies and medications to be avoided (until the Monitoring Team member mentioned it to the PCP during the onsite visit). Given her osteoarthritis and periodic symptoms, focused

evaluation and treatment of this area was needed.

- During an MBSS in December1998, Individual #429 had dysphagia when drinking thick liquids. On 3/15/05, an MBS indicated aspiration when a large bolus of cold thin liquid was provided. On 9/27/11, a PEG-tube was placed due to severe dysphagia, which developed following an arytenoidectomy. On 10/22/11, she underwent a tracheostomy for respiratory distress and stridor associated with obstructive sleep apnea. On 12/26/12, she underwent a tracheostomy revision to allow a larger bore tracheal tube for more effective clearing of secretions. On 5/19/17, she vomited, followed by aspiration pneumonitis. On 6/5/17, she vomited, followed by treatment of acute bronchitis. Individual #429 had had no gastric emptying study or testing to rule out significant reflux with aspiration.

  Since June 2017, she had had no respiratory distress. On 9/28/17, she developed purulent tracheal secretions, but no fever or hypoxia and minimally coarse breath sounds. She recovered without complications. She was provided formula feeding at an intermittent slow drip rate four times daily.

  The AMA, dated 8/22/17, noted that she had pulled out her trach tube three times in the previous quarter. On 10/1/17, she was found with the tracheostomy lying on her bedside table, which would have been beyond her reach and ability. According to the Medical Director she can cough her trach tube out, but cannot untie her tracheostomy strings. On 10/2/17, the IDT held an ISPA meeting and discussed that staff had completed in-service training during which they were told not to touch medical equipment, but to get the nurse if something was needed. The IDT believed there were new staff that were not familiar with the inner cannula or the tracheostomy tube. All three shifts of direct support professionals were to be provided an additional in-service training session.

  However, in conjunction with the IDT, the PCP had not put a plan in place to prevent or minimize dislodging of the inner tracheal tube (e.g., discussion of frequency of monitoring, type of monitoring, referral to Ear, Nose, and Throat for options, etc.). The ISPA reviewed with the staff the need to contact the nurse if the inner cannula was found dislodged, but did not address etiologies of why this occurred. Additionally, although Individual #429 experienced episodes of emesis followed by respiratory distress, there was no information indicating the PCP had considered delayed gastric emptying or reflux aspiration as potential contributing causes in this high-risk individual. If these conditions were present, additional medical treatment and/or surgical options would need to be considered.

- Individual #429 had six infections (i.e., four respiratory and two cutaneous) reported in the year prior to the ISP, dated 8/22/17. On 10/12/17, she underwent VNS replacement and initially had a benign post-operative course. On 10/30/17, the neurosurgeon saw her and recommended no new orders. Then, from 10/31/17 to 11/7/17, she was hospitalized for cellulitis of her neck and axilla, with drainage from the incision site. She had developed a Methicillin-resistant Staphylococcus aureus (MRSA) infection. The infection was considered superficial. There were specific instructions to ensure the incision was protected from her hands and chin. This healed without problems, but then she developed purulent drainage from a ruptured blister at the VNS scar site. She was prescribed Bactrim and Bactroban.

  She had a history of osteoporosis with administration of yearly intravenous (IV) Reclast in the past. Due to difficulties in

obtaining IV access, orders were changed to start Prolia and discontinue Reclast. On 7/6/17 and 1/22/18, Prolia was administered. There is the association of Prolia with increased infections of the skin. However, based on documentation provided, neither the PCP nor the Pharmacy Department discussed this potential correlation, heightened monitoring, or conducted further review to determine whether or not there had been an increase in the number or severity of infections for Individual #429.

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, the one action step assigned to a PCP was implemented. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	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. The one action step assigned to a PCP was 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			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
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: a. and b. The documentation the Center submitted was insufficient to assess these indicators. The Monitoring Team will work with State Office on a solution.											

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: Continued improvement was noted with regard to the quality of the QDRRs. It was also positive that when prescribers agreed to the Clinical Pharmacist's recommendations for the individuals reviewed, documentation was presented to show they implemented them. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
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;	89% 16/18	2/2	2/2	2/2	2/2	2/2	2/2	1/2	2/2	1/2
	ii. Benzodiazepine use;	100% 9/9	2/2	N/A	2/2	2/2	N/A	2/2	1/1	N/A	N/A
	iii. Medication polypharmacy;	85% 11/13	N/A	2/2	2/2	N/A	2/2	0/2	1/1	2/2	2/2
	iv. New generation antipsychotic use; and	92% 11/12	2/2	2/2	N/A	2/2	1/2	2/2	2/2	N/A	N/A
	v. Anticholinergic burden.	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1
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.	100% 5/5	N/A	1/1	1/1	2/2	N/A	N/A	N/A	1/1	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, the QDRRs for the individuals reviewed addressed the necessary components. The following concerns were noted:

- Individual #300's QDRRs indicated she was not treated with polypharmacy, but she was prescribed alendronate, calcium, and cholecalciferol for osteoporosis.
- The Clinical Pharmacist did not reference the most recent lab results in Individual #510's QDRR, dated 10/6/17 [i.e., complete blood count (CBC) on 8/28/17, and Comprehensive Metabolic Panel (CMP) on 8/28/17], and Individual #429's QDRR, dated 12/10/17 (i.e., CMP on 11/23/17).
- For Individual #184, in discussing the risk for metabolic syndrome, the Clinical Pharmacist did not include the fasting blood glucose reading of 140, which is high.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was presented to show they implemented them.

Dental

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

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

#	Indicator	Overall Score	Individuals: 248	199	284	430	184	300	510	503	429
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1	N/A	0/1	0/1	0/1	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/7	0/1		0/1	0/1	0/1	0/1	0/1		0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7	0/1		0/1	0/1	0/1	0/1	0/1		0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7	0/1		0/1	0/1	0/1	0/1	0/1		0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1		0/1	0/1	0/1	0/1	0/1		0/1

Comments: a. and b. Individual #199 and Individual #503 were edentulous, but were part of the core group, so full reviews were conducted. Individual #429 also was edentulous, but her IDT identified her as at medium risk for dental. Her IDT had not included a goal/objective in the ISP/IHCP. The Monitoring Team reviewed six additional individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

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

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not rated (N/R)									
Comments: Individual #199, Individual #503, and Individual #429 were edentulous. c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed and implemented a process to ensure inter-rater reliability with the Centers.											

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: It was good to see that the individuals reviewed received the dental treatment they needed. Given that over the last two review periods and during this review, individuals reviewed received prophylactic care based on their oral hygiene needs (Round 11 – 100%, Round 12 – 100%, and Round 13 – 100%), and individuals reviewed and/or their staff received tooth brushing instruction twice a year (Round 11 – 100%, Round 12 – 100%, and Round 13 – 100%), Indicators a and b will move to the category requiring less oversight. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A
b.	Twice each year, the individual and/or his/her staff receive tooth-	100%	1/1		1/1	1/1	1/1	1/1	1/1		

	brushing instruction from Dental Department staff.	6/6									
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.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 3/3	N/A		1/1	1/1	N/A	N/A	1/1		
e.	If the individual has need for restorative work, it is completed in a timely manner.	N/A	N/A		N/A	N/A	N/A	N/A	N/A		
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A	N/A		N/A	N/A	N/A	N/A	N/A		
	Comments: a. through f. Individual #199, Individual #503, and Individual #429 were edentulous. It was good to see that the remaining individuals reviewed received the dental treatment they needed. Three individuals reviewed (i.e., Individual #430, Individual #184, and Individual #510) had needs for restorative work, but justification was provided for delaying or forgoing the work.										

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: For the dental emergency reviewed, the Dental Department provided timely dental treatment, and the PCP provided pain management. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1			1/1						
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 1/1			1/1						
	Comments: a. through c. On 8/25/17, Individual #284 walked into the Dental Office with complaints of a dental emergency. The Dental Department staff conducted a limited dental exam, and took x-rays. The PCP provided a prescription for Tylenol to address the individual's pain. When follow-up occurred on 9/7/17, the dental issue had resolved.										

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	248	199	284	430	184	300	510	503	429
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of	33% 1/3	N/A	N/A	N/A	N/A	1/1	N/A	N/A	0/1	0/1

	suction tooth brushing.										
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	33% 1/3					0/1			1/1	0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3					0/1			0/1	0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/3					0/1			0/1	0/1

Comments: a., b., and d. Individual #184's ISP included an action step for suction tooth brushing twice daily. Based on the data submitted for the period between 10/25/17 and 1/25/18, most days, he only received suction tooth brushing once daily. The QIDP monthly reviews did not reference data for suction tooth brushing.

Individual #503 and Individual #429 were edentulous, but the Dental Department recommended beneficial suction brushing twice daily. From the data provided for the period between 10/25/17 and 1/25/18, Individual #503 generally received the suction brushing twice daily, but Individual #429 rarely received it twice a day, and on several dates received none at all. The QIDP monthly reviews did not reference data for suction tooth brushing.

c. For Individual #184, an IPN, dated 2/23/17, indicated that the Registered Dental Hygienist (RDH) showed caregivers how to apply and confirmed use of the Plak-Vac suction toothbrush. The RDH concluded: "review of supports show appropriate dental supports." From this documentation, the Dental Department appeared to complete one training/monitoring session during approximately nine months. The audit tool guidelines indicate: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." Based on a review of Individual #184's ISP/IHCP, the IDT had not defined monitoring parameters.

Outcome 9 – Individuals who need them have dentures.

Summary: N/A

#	Indicator	Overall Score	Individuals: 248	199	284	430	184	300	510	503	429
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: N/A

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: Based on discussions with State Office, the Center did not submit acute care plans. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, the lack of acute care plans consistent with relevant nursing standards for all acute issues/occurrences is a substantial deviation from standard practice and needs to be corrected.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									
Comments: a. through f. Based on discussions with State Office, the Center did not submit acute care plans. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, the lack of acute care plans consistent with relevant nursing standards for all acute issues/occurrences is a substantial deviation from standard practice and needs to be corrected. The Monitoring Team has discussed this issue with State Office. Given the current issues with acute care plans, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist, and/or deviated from current nursing standards of practice. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should continue to work with State Office to correct this issue.											

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #248 – falls, and choking; Individual #199 – GI problems, and weight; Individual #284 – falls, and constipation/bowel obstruction; Individual #430 – infections, and constipation/bowel obstruction; Individual #184 – aspiration, and fractures; Individual #300 – choking, and falls; Individual #510 – falls, and constipation/bowel obstruction; Individual #503 – skin integrity, and other: hypothermia; and Individual #429 – falls, and infections). None of the goals/objectives reviewed were clinically relevant, achievable, and/or measurable. c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of nursing supports and services to these nine individuals.											

Outcome 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 several review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429

a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/10	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/1	N/A
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2

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

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly. The exception was the IHCP for infections for Individual #430.

b. The following provide examples of concerns related to the actions IDTs took in response to individuals' risks:

- Based on the ISPAs provided, it did not appear that Individual #248's IDT recognized the significant increase in his falls. On 12/21/17, a fall resulted in a serious injury (i.e., three sutures to his eyebrow) when he hit his head on a dresser. However, the IDT did not conduct a comprehensive review and analysis of his falls. Given that the documentation clearly indicated that Individual #248's mental status changed right after this fall (i.e., agitated, unable to follow direction), which indicated the potential for traumatic brain injury, this was concerning. However, except for an OT/PT assessment for dressing himself (i.e., he fell while dressing), the IDT put no proactive interventions in place. The documentation did not indicate that the IDT took into consideration any changes in his medication, his vision issues (i.e., he had cataracts), and/or his past fracture of the 5th left metatarsal in 2012, the multiple bruises found on his body per the IPNs, and the frequent episodes during which he was a victim in peer-to-peer incidents (i.e., eight from 7/1/17 to 12/16/17, according to IV.1-20 documentation). In addition, the data addressing falls were inconsistent between documents. At the time of the review, even after a significant injury, the IDT had not taken any meaningful actions to protect Individual #248 from further falls and injuries.
- According to an ISPA, dated 11/30/17, Individual #199's IDT determined without supporting data that her numerous episodes of emesis were due to non-compliance with her PNMP, diet, and medications. ISPA documentation indicated that she had a diagnosis of borderline personality disorder, which is associated with self-harm behaviors and attention-seeking behaviors. Based on review of ISPAs, the IDT had not collected and/or analyzed important data and healthcare information, such as when the episodes of emesis began; whether or not any of it was self-induced; her frequent requests for Tylenol and Motrin for stomach pain, which an ISPA noted she took six to 15 times a month; changes in medications; her large hiatal hernia; her past fundoplication (which might have come unraveled); weight issues and their effect on her GERD; use of antibiotics for wounds and a UTI; and hypothyroidism. With regard to her weight issues, edema, and loss of mobility over the past two years, the ISPAs did not show that the IDT analyzed her actual calorie intake, fluid intake, issues related to her osteoarthritis and pain,

and anemia, which might have contributed to her loss of mobility.

- Individual #284 had a significant number of falls, but based on the ISPAs provided, her IDT did not meet to analyze her falls or put actions in place to prevent them. The PNMT assessment concluded the cause of her falls were behavioral. However, fall data included in this assessment described falls that resulted in her hitting her head on a wall while getting into the shower (4/27/17), falling on her back (5/6/17), falling twice due to her shoes being too big (8/5/17), and a fall from a chair hitting her head on a table (8/29/17), which did not fall into the category of behavioral issues. Consequently, at the time of the review, no interventions were in place to protect this individual from falls and injuries.
- It did not appear that Individual #430's IDT recognized that the addition of a narcotic for pain management increased his existing risk related to constipation. Documentation did not show that the individual's fluid, fiber, or current activity level were assessed when the pain medication was initiated and supports put in place in order to prevent episodes of constipation. This was only addressed after the individual had an increase in the use of PRN medications due to constipation.
- According to an ISPA, dated 11/18/17, Individual #184 had a history of aspiration pneumonia (i.e., 4/20/16, 8/28/16, 11/16/16, 10/30/17), bacterial pneumonia (i.e., 5/25/16), and between November 2016 and November 2017, had 30 episodes of emesis. A MBSS from 11/10/16 showed silent aspiration. The ISPAs reviewed indicated that the IDT was trying to determine the cause of Individual #184's episodes of aspiration. However, for a number of issues, data were not presented and aggregated to identify any trends or patterns that might reveal some of the potentially contributing factors, and assist the IDT in developing proactive action steps. For example, the IDT did not aggregate vomiting episodes and compare them with constipation episodes, or analyze poor compliance with positioning instructions that the PNMT monitoring identified, complaints of stomach pain, changes in feeding schedules and formulas, the use of the mouth sprays, any oral intake, medication changes, meal refusals, other health issues (e.g., transurethral resection of the prostate), and episodes of self-induced vomiting and if they gave him relief from pain/full feelings. In addition, according to the ISPAs addressing the Root Cause Analysis, the IDT did not establish measurable objectives by which to determine progress. From the documentation reviewed, the IDT needed to monitor a number of issues, including staff's adherence to the PNMP, which raised significant concern as a potential cause of his recurrent aspiration pneumonia. However, it did not appear that the IDT put such monitoring systems in place, even after holding root cause analysis meetings. It also was not clear how often the IDT would meet to discuss the impact of the actions they did put in place. As discussed with regard to the medical Outcome #5 and Outcome #8, it was particularly concerning that a DNR Order was in place for Individual #184, when the IDT, including the PCP, had not taken sufficient actions to address his recurrent aspiration pneumonia.
- Although Individual #184 had not had any recent fractures during the ISP year, the ISPA, dated 3/7/17, noted that he "will need to be monitored when standing to prevent falls "due to his weak status." In addition, the ISPA, dated 12/5/17, contained information from 5/25/17, noting that the individual had an unsteady gait. On 10/30/17, direct support professionals reported he had an unsteady gait with two near falls. His AMA described a significant history of fractures: 1977 - compression fracture of L1, 1981 - base of 1st metacarpal of the left hand, no date - oblique fracture of the neck of the 5th metacarpal, 2009 - fracture of the right great toe and left 4th metacarpal, 2010 - fracture of the right 4th and 5th ribs, and 2011 - fracture of the left foot. Based on the ISPAs and IHCP reviewed, the IDT had not put proactive nursing interventions in place to actively assess and potentially prevent him from falling and possibly sustaining another fracture.
- An IPN, dated 10/4/17, indicated that staff notified the nurse that Individual #300 fell and stood up on her own. No details were provided regarding where she fell, what she was doing at 4:00 a.m. when she fell, whether the fall was witnessed (if it was not witnessed, then a full assessment would be needed, she should not have been moved unnecessarily, and the PCP should

have been notified), any complaints of dizziness, if vital signs were taken at the time, the time the nurse assessed her (i.e., the IPN was entered at 2:18 p.m.), and her status throughout the day, since the IPN was written hours after the incident. The next RN monthly IPN, dated 10/4/17 at 8:28 p.m., noted Individual #300 had not had any falls that month, so it appeared that the RN was not aware of the individual's fall that morning.

The RN IPN, dated 10/6/17 at 11:14 a.m., noted that the individual was not eating meals, had been in bed for the past four to five days, had stiffness in her legs, "asked for help from different persons including this nurse but when assisting refuses to help herself or DSP [direct support professional] to stand up." The note indicated Individual #300 was rubbing on the left hip as if injured, but "No injuries noted. No redness, swelling, bruising, noted to hip area. No recent falls." At 5:22 p.m. the same day, the RN added an addendum to this IPN noting the fall on 10/4/17, notifying the PCP of the fall, and indicating the individual was sent for x-rays. The note also indicated that Individual #300 had "dark black, red and yellow bruising underneath butt cheek area bilaterally" after the initial x-rays were taken, but the note did not identify who discovered the bruising. This note also indicated that the PCP was notified and ordered additional x-rays. A Nurse Practitioner IPN, dated 10/6/17 at 3:04 p.m., indicated that the RN reported the fall on 10/3/17 (date should be 10/4/17), and that Individual #300 had been ambulating without problems, but "has spells of complaints of pain." This, however, was not what was reflected in the Communication Log, according to the ISPA, dated 10/7/17. The notes from the Communication Log for 10/5/17 indicated that Individual #300 could not sit up in bed when prompted to get her medications and that when assisted up to the medication room, "it seemed as if her legs gave out." The Log indicated that staff assisted Individual #300 to the floor and the home nurse assessed her. No IPN documentation was found to support the nurse assessing her.

The results of the x-rays indicated that Individual #300 had a L3 50% compression fracture. An ISPA, dated 10/17/17, indicated that since the fall, the individual had been refusing to get out of bed for meals, activities, and was having difficulty getting up to use the bathroom, as well as not being able to sit on the toilet. After attempts to do so were unsuccessful, Individual #300 would request to lie back down. The documentation provided did not indicate how she was going to the bathroom. However, a temporary PNMP was not implemented until 10/10/17, addressing how staff were to modify the assistance they provided to Individual #300 for bed mobility and transfers. On 10/10/17 at 12:10 p.m., she was sent to hospital via 911 for lethargy and "not being able to breathe on her own." She was diagnosed with a UTI positive for gram negative rods and E. coli. In addressing Individual #300's change(s) of status, the documentation showed a significant lack of assessment, communication, prompt interventions, and training amongst the team members and residential staff.

- Individual #503's IDT did not appear to hold an ISPA meeting to discuss a Stage II decubitus to the stoma site and to develop a plan to monitor its healing, and update the IRRF and the IHCP. At the time of the Monitoring Team's review, the risk level for skin integrity in the IRRF was rated as "low." It was also very concerning that when, on 7/21/17, the LVN identified the pressure sore, it was already a Stage II decubitus according to the PCP IPN, dated 7/21/17.

Outcome 6 – Individuals receive medications prescribed in a safe manner.	
Summary: During this review, good improvement was seen with medication nurses following individuals' PNMPs during medication administration. In addition, for the three previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine	Individuals:

rights; and 2) nurses adhering to infection control procedures while administering medications. 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. All of the remaining indicators will also continue in active oversight.

#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
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.	50% 2/4	N/A	1/1	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.	50% 1/2	N/A	N/A	N/A	N/A	1/2	N/A		N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									

f.	Individual's PNMP plan is followed during medication administration.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8	1/1	1/1	1/1	1/1	0/1	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 #248, Individual #199, Individual #284, Individual #430, Individual #184, Individual #300, Individual #503, and Individual #429.

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 following concerns were noted:

- For Individual #184, the IHCP did not include lung sound assessments. During the observation, the medication nurse listened to the individual's lung sounds. However, after administering Chloraseptic mouth spray and reassessing his lungs, she noted some congestion. After having him cough, she reported his lungs cleared. Initially, she documented lung sounds were clear. However, after the Monitoring Team member asked her about the documentation, the nurse added a description of the assessment she conducted and the findings in the "Comment Section" in IRIS.
- For Individual #503, the IHCP only included lung sounds assessments monthly, which was not frequent enough given the level of risk.

f. It was good to see that medication nurses implemented the individuals' PNMPs during the medication administration observations.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was that the nurse for Individual #184 placed the dressing from the Mic-Key button on the counter in the medication room.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Although some individuals' IDTs referred them to the PNMT when necessary, other individuals' IDTs did not, and the PNMT did not make self-referrals for these individuals. In addition, overall, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
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	0/2	0/1	N/A	0/1	N/A	0/2	N/A	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/9	0/2	0/1		0/1		0/2		0/1	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9	0/2	0/1		0/1		0/2		0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/9	0/2	0/1		0/1		0/2		0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/2	0/1		0/1		0/2		0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	78% 7/9	N/A	0/1	2/2	1/1	2/2	N/A	1/2	1/1	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of	0% 0/9		0/1	0/2	0/1	0/2		0/2	0/1	

		interventions;										
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	11% 1/9		0/1	1/2	0/1	0/2		0/2	0/1	
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9		0/1	0/2	0/1	0/2		0/2	0/1	
	v.	Individual has made progress on his/her goal/objective; and	0% 0/9		0/1	0/2	0/1	0/2		0/2	0/1	
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9		0/1	0/2	0/1	0/2		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 falls for Individual #248; GI problems for Individual #199; weight for Individual #430; choking, and falls for Individual #300; aspiration for Individual #503; and aspiration, and GI problems for Individual #429.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable, as well as 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 goal/objectives were included. These areas of need included: aspiration for Individual #199; weight, and falls for Individual #284; fractures for Individual #430; aspiration, and GI problems for Individual #184; weight, and falls for Individual #510; and GI problems for Individual #503.

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

- Between January 2017 and July2017, Individual #199 experienced 23 episodes of emesis, but it was not until August 2017, when 27 episodes of emesis occurred that her IDT referred her to the PNMT.
- Individual #510's IDT did not refer her to the PNMT to address her weight loss over the course of the year. Each quarter, the IDT noted a decrease in weight (7.5%, then 8.5%, and then 9%), but did not make a referral.

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. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: weight for Individual #284.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, integrated progress reports with 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: Often, IDTs did not take immediate action when the risk to the individuals increased or they experienced a change in status. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
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.	6% 1/18	0/2	0/2	0/2	1/2	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.	38% 5/13	0/1	1/2	1/2	1/2	1/2	1/1	0/2	0/1	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	67% 4/6	N/A	N/A	1/1	0/1	2/2	N/A	1/1	0/1	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCP for which documentation was found to confirm the implementation of the PNM action steps that were included was for fractures for Individual #430. In many instances, monthly integrated reviews referenced numbers of occurrences of physical and nutritional management issues, such as falls, emesis, choking, aspiration pneumonia, and weight gain/loss, but they did not review the implementation of action steps included in IHCPs.

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

- Based on the documentation provided, Individual #248's IDT did not meet in response to an increase in falls in December 2017. On 12/28/17, the IDT held an ISPA meeting to discuss an injury that occurred on 12/21/17, due to a fall that occurred when the individual was dressing. On 12/22/17, the PT conducted an assessment of his dressing skills. However, the PT assessment only focused on the individual's balance when he was dressing himself, and did not address the other three falls that occurred during the month of December 2017. As a result, the IDT did not have complete information with which to make decisions.
- From January 2017 to July 2017, Individual #199 had 23 episodes of emesis, but the IDT did not make a referral to the PNMT until 27 episodes occurred within a single month (i.e., August 2017).
- Individual #284 had a weight goal focused on increasing her weight to the middle of the recommended weight range, which would have meant an 11-pound weight increase. She did not achieve this goal. Rather than addressing the reason behind her inability to gain weight, the IDT replaced the goal with one that required her to maintain her current weight. The IDT offered no rationale as to why an increase was no longer desired.
- Between June 2017 and December 2017, Individual #430's body mass index (BMI) increased from 22.7 (i.e., normal weight) to 27 (overweight). However, based on documentation provided, the IDT did not intervene.
- According to an ISPA, dated 12/6/17, staff working with Individual #184 failed to implement his PNMP positioning instructions during 12 of 17 observations, yet the IDT did not request a consult from the PNMT or the PT to address the issue.

Based on review of the documentation provided, no evidence was found to show that the IDT developed any plan to address the lack of compliance. Given his ongoing problems with emesis, this was a significant concern. • Even after the PNMT indicated that the underlying cause of Individual #503's emesis was inadequate positioning, the IDT did not put a plan in place in collaboration with the PNMT to increase monitoring or address the cause of the inadequate positioning.

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. These indicators will remain in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	38% 15/40	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	50% 2/4	
Comments: a. Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during seven out of 19 observations (37%). Staff followed individuals' dining plans during six out of 19 mealtime observations (32%). Staff completed transfers correctly during two out of two observations (100%).			

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/1					N/A			0/1	N/A
Comments: a. As noted above, Individual #503's IDT determined that attempts to return to oral intake should be put on hold until the emesis decreased, but offered no plan to address the emesis.											

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 a few OT/PT goals/objectives developed for individuals reviewed were clinically relevant, and measurable, but they were not included in individuals' ISPs or incorporated through ISPAs. Overall, for the individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	20% 2/10	0/1	0/3	0/1	0/1	1/1	0/1	0/1	1/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	20% 2/10	0/1	0/3	0/1	0/1	1/1	0/1	0/1	1/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	10% 1/10	0/1	0/3	0/1	0/1	0/1	0/1	0/1	1/1	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/10	0/1	0/3	0/1	0/1	0/1	0/1	0/1	0/1	
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10	0/1	0/3	0/1	0/1	0/1	0/1	0/1	0/1	

Comments: a. and b. The goals/objectives that were clinically relevant and achievable, as well as measurable, and were included in ISPs/ISPAs were those for Individual #184 (i.e., ambulating 300 feet with a rollator), and Individual #503 (i.e., wiping her mouth). Although Individual 199's goal/objective for direct therapy (i.e., standing without losing balance), and Individual #430's goal/objective (i.e., increasing active range of motion) were clinically relevant, they were not included in the ISPs or incorporated through ISPAs. Individual #429 did not have a need for formal OT/PT supports. She was part of the core group, though, so a full review was conducted.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, integrated progress reports with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

For Individual #503, the integrated progress reports did include data, but the data showed no correct responses for August, September, October and November 2017, and only one correct response in the months of December 2017 and January 2018. However, the IDT did not address this lack of progress, by, for example, modifying the training or the goal. 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 oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	91% 10/11	1/1	2/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/3	N/A	0/1	N/A	0/1	0/1	N/A	N/A	N/A	N/A
Comments: a. For Individual #199's unsupported standing program, a monthly note, dated 9/27/17, showed implementation for the first month, but the Center did not provide additional notes to show implementation in the months that followed. On 12/4/17, a new direct program started. b. ISPAs were not found to show discussion or IDT approval of discharge from formal OT/PT supports.											

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%, and Round 13 – 77%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for this indicator, scores continue below, but the total is listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	609	140	347	206	223	262	484	337	203
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.									

#	Indicator										
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.	77% 27/35	2/2	1/1	1/2	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		382	465	368	621	415	31	360	240	306
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	1/1	0/1	0/1	0/1	1/1	1/1
		Individuals:									
#	Indicator		542	312	519	123	248	505	293	215	446
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		193	464	545	120	199				
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/2	0/1	0/1				

Comments: c. The Monitoring Team conducted observations of 35 pieces of adaptive equipment. Based on observation of Individual #347, Individual #382, Individual #415, Individual #31, Individual #360, and Individual #199 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors. Individual #545 and Individual #120 were not wearing their padded knee pants.

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

This Domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition, and communication. One of these was moved to, or were already in, the category of requiring less oversight after the last review. Presently, none of these indicators will move to the category requiring less oversight.

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

Many individuals were not actively engaged when the Monitoring Team conducted observations throughout the week (and when the Center conducted its own observations). This is an important area upon which Abilene SSLC should focus. It likely will require special efforts that address improving engagement opportunities for groups of individuals as well as for specific individuals. It was, however, good to see that the Center was measuring engagement regularly.

For the ISPs, without personal goals that were implemented and for which data were collected, it was impossible to determine progress. IDTs need to monitor the implementation of all action plans and address barriers to implementation.

Two SAPs met criteria for content. SAPs contained some, but not all of the required components that set the occasion for good teaching that is likely to result in skill acquisition.

One of six SAPs that were observed was implemented correctly. Less than half of the SAPs had regular integrity checks.

Three SAPs that had reliable data also showed progress. For the others, either there was no progress or no data. When individuals were not making progress, actions were not taken.

There was activity occurring between Abilene SSLC and the public school. Additional attention to the public-school program by the IDT is required.

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

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Without personal goals that are individualized, measurable, and then implemented, and, for which data are collected, it is impossible to determine progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	248	429	300			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
4-7. For personal goals that did not meet criterion as described above, there was no basis for assessing progress in these areas. For 13 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 (i.e., indicator 3).

For the one goal where valid data were available, Individual #248 was not making consistent progress towards learning to choose his clothing.

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

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	248	429	300			
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. Overall, direct support staff were generally able to describe individual's health and behavioral risks. Staff, however, were not fully implementing ISPs, so it was difficult to verify that they could exhibit competence in implementing support plans. ISPs rarely included detailed instructions to guide staff when implementing the ISP.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report. IDTs need to monitor the implementation of all action plans and address barriers to implementation.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Three SAPs that had reliable data (indicator 5) also showed progress. For the others, either there was no progress or no data. When individuals were not making progress, actions were not taken. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
6	The individual is progressing on his/her SAPS	13% 3/23	1/3	0/2	0/2	0/3	0/3	0/3	1/2	1/3	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% 0/20	0/2	0/2	0/2	0/2	0/3	0/3	0/2	0/2	0/2
9	Decisions to continue, discontinue, or modify SAPs were data based.	0% 0/20	0/2	0/2	0/2	0/2	0/3	0/3	0/2	0/2	0/2

Comments:

6. Based upon a review of data presented in the text of the QIDP Monthly Reports and graphically in the Client SAP Training Progress Note, it was determined that progress was being made on three SAPs. This included Individual #640 learning to take his blood pressure, Individual #154 leaving his clothes on when leaving the kitchen, and Individual #474 reading his social skills. Progress could not be assessed on three SAPs either because there was no graph and no review in the monthly reports (Individual #423 - playing a game), or the date of step change was not identified (Individual #154 - allow a person to sit next to him; Individual #248 - street crossing).

7. The objective was not met for any of the objectives, therefore, this indicator was scored N/A.

8. In no case was there evidence of action taken to address the lack of progress. While it was noted that jewelry would be added to Individual #2's mailing a card SAP, it was not clear how this addition related to the skill, nor was there evidence that this had occurred. For four consecutive months, it was noted that the program development specialist would assess additional sensory items for

Individual #49, but there was no evidence that this had been completed. Lastly, for three consecutive months, it was noted that the program development specialist would try to assess the barriers to Individual #561's learning to thread a needle, but again, there was no evidence that this had occurred.

9. This indicator was rated as zero for all 20 SAPs. Although data were reviewed, this review did not result in actions to support progress.

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

Summary: Two SAPs met criteria for content. SAPs contained some, but not all of the required components, that is, components that set the occasion for good teaching that is likely to result in skill acquisition. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 640	199	423	2	49	561	154	474	248
13	The individual's SAPs are complete.	8% 2/26	2/3	0/2	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:
13. Two of the 26 SAPs were considered complete. These were the SAPs in which Individual #640 was learning to apply deodorant and take his blood pressure.

In the majority of the remaining SAPs, the following components were evident: task analysis where appropriate, behavioral objective, operational definition of target behavior, relevant discriminative stimulus, specific consequence for correct responding, plans for maintenance and generalization, and documentation methodology.

Missing were instructions specific to the task, a teaching schedule that clearly included the number of trials to be conducted during identified days of instruction (exceptions were activities that typically occur once daily such as showering), and consequences for incorrect responding. Several plans included generic instructions regarding how to use and fade prompts, how to reinforce correct responses and respond to incorrect responses, and steps to take when the individual refuses. These appeared to be plans developed using an older format.

Outcome 5- SAPs are implemented with integrity.

Summary: One of six SAPs that were observed was implemented correctly. Less than half of the SAPs had regular integrity checks. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 640	199	423	2	49	561	154	474	248
14	SAPs are implemented as written.	17%	N/A	0/1	0/1	0/1	N/A	1/1	0/1	0/1	N/A

		1/6									
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.	42% 11/26	3/3	1/2	0/3	1/3	2/3	0/3	1/3	2/3	1/3

Comments:
14. The Monitoring Team was able to observe SAP implementation for six individuals. A SAP observation was not scheduled for Individual #49 because his home was on restriction to due to the flu, Individual #248 was not at home during his scheduled observation, and the nurse was administering medications at another home during Individual #640's scheduled SAP observation.

Individual #561's personal information SAP was implemented as indicated in the plan.

For the other five individuals, there were problems with SAP implementation.

- Individual #199 was observed completing her exercises, but rather than having her sit in a sturdy chair, staff had her complete these while seated in her wheelchair.
- Individual #423 was to record her name and date when completing the trip request form, but staff had her write her name and the purpose of the trip.
- Individual #2 received praise for applying lotion to her hands, but she did not receive the hair clip as indicated in the SAP.
- Individual #154 put on his shirt and shorts when instructed to do so, but a timer was not set for three minutes, nor was candy presented contingent upon his completing a three-minute walk throughout the living room.
- Individual #474 was not asked to sit at a table to work on his social skills. Further, the staff member did not have him review the social skills guidelines before asking him to greet her appropriately.

15. Per state policy, SAP integrity should be assessed at a minimum of twice annually. Based upon documentation provided, 11 of the 26 SAPs had been monitored at least once over the previous six-month period. While the facility indicated that six additional SAPs had been monitored for data reliability, a review of the completed monitoring sheets revealed that no observation of the SAP occurred. This included two SAPs each for Individual #199 and Individual #2, and all three SAPs for Individual #561.

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

Summary: SAP data were reviewed and graphed monthly. This was good to see and has been the case for this review and the past two reviews, too. But given the problems with correct implementation (indicator 14) and with making changes when there was no progress (indicator 8), these two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 640	199	423	2	49	561	154	474	248
16	There is evidence that SAPs are reviewed monthly.	88% 23/26	3/3	2/2	0/3	3/3	3/3	3/3	3/3	3/3	3/3

17	SAP outcomes are graphed.	88% 23/26	3/3	2/2	1/3	3/3	3/3	3/3	2/3	3/3	2/3

Comments:
16. There was evidence that 23 of the 26 SAPs had been reviewed monthly. The exceptions were the three SAPs for Individual #423. A review of her most recent monthly QIDP report revealed no comments on her progress or lack thereof on two of these SAPs. Data were reported for the month of January 2018 on her completing a trip request form.

17. Graphs were available for all, but one SAP. The exception was the SAP to teach Individual #423 to play a game. Of the remaining 25 SAPs, graphs were helpful in determining progress in all, but two. These exceptions were in cases where the individual was working on the second or third step of the program, but the date of step progression was not indicated. This made it difficult to determine progress or the lack thereof for Individual #154 (allow a staff member to sit next to him) and Individual #248 (street crossing). Staff are advised to exclude refusals from the reported total number of monthly trials completed.

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

Summary: Many individuals were not actively engaged when observed by the Monitoring Team throughout the week (and when the Center conducted its own observations). This is an important area upon which Abilene SSLC should focus. It likely will require special efforts that address improving engagement opportunities for groups of individuals as well as for specific individuals. It was, however, good to see that the Center was measuring engagement regularly. With sustained high performance, this indicator (19) might be moved to the category of requiring less oversight after the next review. All three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
18	The individual is meaningfully engaged in residential and treatment sites.	38% 3/8	1/1	1/1	0/1	0/1	Not rated	0/1	0/1	1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	33% 3/9									

Comments:
18. Eight of the nine individuals were observed in their homes and day program sites. The exception was Individual #49 whose home was on isolation due to the flu. Of these eight individuals, three (Individual #640, Individual #199, Individual #474) were considered to be meaningfully engaged. Although Individual #640 and Individual #474 were not observed at school, they did attend for most of the

week of the onsite visit. When they were observed at home, they were engaged. Individual #199 was observed working and either eating or playing a game while at home.

- Individual #423 was often idle while at home and she did not have any scheduled activities outside of her home.
- Individual #2 was observed repeatedly in her bedroom without meaningful engagement.
- Individual #561 was not engaged when observed at home and his schedule had not been revised to include scheduled activities outside of the home since he had withdrawn from school.
- Other than one observation at lunch, Individual #154 was repeatedly observed to be unengaged, lying naked on the couch, with a sheet covering him.
- Individual #248 was reported to spend most of his time walking around campus.

A review of work and/or day program attendance over a three-month period revealed very poor participation by three of the four individuals who were scheduled for these activities. Specifically, Individual #199 attended an average of 29% of scheduled work sessions, Individual #474 attended work an average of 32% of the time and the activity center 27% of the time, and Individual #248 attended the activity center only 26% of the time. It should be noted that Individual #248's attendance was increasing over the three-month period. Only Individual #49 had acceptable attendance records spending on average 79% of the scheduled time at the activity center.

Individual #423 and Individual #2 had been discontinued from work in January 2018 and April 2017, respectively. There was no evidence of alternative activities being added to their daily schedules. The facility reported none noted when asked for Individual #154's attendance at either work or the activity center. Neither Individual #640 nor Individual #561 had any scheduled activities at the facility outside of their home environments.

19. The facility had established a system of assessing engagement in each home and day program site once monthly. Engagement goals were established for all settings, ranging from 45% to 90% for homes, 50% to 80% for activity centers, 60% to 80% for senior citizens' programs, and 90% for work sites.

21. Engagement goal frequencies and levels were achieved in both home and day program sites for Individual #199, Individual #423, and Individual #49. For all others, the frequency and/or level was not consistently met over a six-month period.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	640	199	423	2	49	561	154	474	248
22	For the individual, goal frequencies of community recreational activities 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
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	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0/9									

Comments:
22. Eight of the nine individuals had goal frequencies for community recreational activities identified in their ISPs. The exception was Individual #474. While there was evidence of access to the community, none of the individuals had achieved their goals.

23. There was no evidence of SAP training in the community for any of the individuals.

24. There was no evidence that the IDTs had met to discuss barriers to community recreational activities or community-based SAP training. It was concerning that the ISPs for Individual #2 and Individual #154 noted that the individual was her/his own barrier.

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

Summary: There was activity occurring between Abilene SSLC and the public school. Some additional attention to the public-school program by the IDT is required. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 640	474							
25	The student receives educational services that are integrated with the ISP.	0% 0/2	0/1	0/1							

Comments:
25. Individual #640 and Individual #474 were enrolled in school at the time of the onsite visit. There was evidence that the QIDP participated in the IEP meeting during which time discussion occurred regarding inclusion and extended school year. This was good to see. The ISP included information about the individual's participation in school and related action plans. Individual #474's ISP included a listing of his IEP objectives. This was not true for Individual #640 as his ISP meeting was held with just two weeks left to the 2016-2017 school year. For neither individual was there evidence that the IDT had reviewed their school progress reports.

It would be advisable for behavioral health services staff to regularly schedule visits to school to ensure that the individual is actively engaged, to support continuity between school and home programming, and to address any problems as they occur.

Also, Individual #561 attended school at the beginning of the current school year. After he withdrew at the end of November 2017, the IDT should have met to review and revise/expand his SAPs and daily schedule.

Dental

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

Summary: For individuals reviewed, IDTs did not have a way to measure clinically	Individuals:

relevant outcomes related to dental refusals. These indicators will remain in active oversight.											
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3	0/1	N/A	N/A	0/1	0/1	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/3	0/1			0/1	0/1				
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/3	0/1			0/1	0/1				
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/3	0/1			0/1	0/1				
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3	0/1			0/1	0/1				
Comments: a. though e. For the three individuals reviewed that had refused dental services, IDTs had not developed specific goals/objectives related to their refusals.											

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: Overall, IDTs did not have a way to measure clinically relevant, achievable, and measurable outcomes related to individuals' formal communication services and supports. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	40% 4/10	2/2	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	10% 1/10	0/2	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/10	0/2	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% 0/10	0/2	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	0%	0/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	been met, the IDT takes necessary action.	0/10									

Comments: a. and b. The goal/objective that was clinically relevant, achievable, as well as measurable was Individual #284's goal related to selecting a preferred radio station using modified visual aids.

The goals/objectives that were clinically relevant, but not measurable were those for Individual #248 related to naming items in pictures, and answering simple "wh" questions, and Individual #429's goal related to pointing to an activity of choice.

c. through e. For the nine individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	248	199	284	430	184	300	510	503	429
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	10% 1/10	0/2	0/1	0/1	0/1	0/1	0/1	1/1	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: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Examples of concerns included:

- Data often showed that communication goals/objectives were not run consistently.
- Documentation was not found to show that reviews were conducted of individuals' Communication Dictionaries to determine whether or not they were effective.

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, they are in working order, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	390	425	621	312	542	321	545		
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	29% 2/7	1/1	0/1	0/1	0/1	0/1	1/1	0/1		
b.	Individual is noted to be using the device or language-based support	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1		

	in a functional manner in each observed setting.	0/7									
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/3									
Comments: a. and b. It was concerning that often individuals' AAC devices often 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, one indicator 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.

Although additional work was needed, it was good to see improvements with regard to the measurability as well as the comprehensiveness of pre- and post-move supports. The IDTs should continue to work on developing comprehensive supports, particularly in the following areas: behavioral and psychiatric history; safety, medical, heath care, therapeutic, risk and supervision needs, outcomes important to the individual; and employment/meaningful day activities.

It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed. Due to consistent findings related to timeliness, the related indicator will move to less oversight. Although the Post-Move Monitor generally paid good attention to detail, some of the areas in which continued efforts were needed related to the PMM consistently basing decisions about supports on reliable and valid data, the PMM correctly scoring the presence or absence supports based on the evidence, and IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports. The remaining indicators will continue in active oversight.

It was positive transition staff had been working with several disciplines on the quality of transition assessments and recommendations, and some improvement was observed. There remained a need, however, with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. It was positive that IDT members participated in transition planning, and that the individuals and/or guardians were involved and kept up-to-date on the decision-making. The CLDPs included numerous pre-move supports for pre-move training, which was a good improvement, but these did not yet fully meet criterion for ensuring that provider staff were competent for either individual reviewed.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.	
Summary: Although additional work was needed, it was good to see improvements with regard to the measurability as well as the comprehensiveness of pre- and post-move supports. The IDTs should continue to work on developing comprehensive supports, particularly in the following areas: behavioral and psychiatric history;	Individuals:

	safety, medical, heath care, therapeutic, risk and supervision needs, outcomes important to the individual; and employment/meaningful day activities. These indicators will remain in active oversight.											
#	Indicator	Overall Score	391	447								
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1								

Comments: Since the last review, three individuals transitioned from the Center to the community. Two were included in this review (i.e., Individual #391, and Individual #447). The Monitoring Team reviewed these two transitions and discussed them in detail with the Abilene SSLC Admissions and Placement staff while onsite.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. To move toward compliance, the IDTs should continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) can accurately judge implementation of each support. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed five pre-move supports for Individual #391, and 19 pre-move supports for Individual #447.
  - For Individual #391, the IDT developed three pre-move supports to ensure the provider had needed equipment and materials, all of which were measurable.
  - The CLDP also included two supports for pre-move training for Individual #391 that did not meet criterion for measurability. To meet criterion, pre-move training supports should address the content of provider staff training, as well as describe the staff to be trained, the training methodologies to be used, the competency criteria, and how competency will be measured. Both supports did describe the provider staff that needed to be trained as well as the broad content areas. Some content areas also provided specific knowledge staff would need to know, while others did not. For example, the habilitation training support included the specific requirements of the mealtime plan, and described the need to watch for coughing after meals and report it to the nurse immediately. On the other hand, the support also included the topic of informal communication strategies, but provided no specific detail. Neither of these supports called for demonstration of staff competence or knowledge, requiring only a copy of the training materials and a signature sheet.
  - For Individual #447, the IDT developed ten supports for environmental and equipment needs and for actions for Center staff to take. These supports were generally measurable, which was positive. In one instance, the IDT could have more clearly stated the expectation. This pre-move support called for the Center to provide a list of any upcoming medical appointments that were already scheduled. The evidence was a list of the scheduled appointments. This support did not include sufficient detail to allow the staff completing the pre-move site review (PMSR) to verify a

complete and accurate list had been provided.

- The IDT for Individual #447 developed nine pre-move training supports. Three supports called for Abilene SSLC staff to complete pre-move competency training in three broad categories (medical and nursing needs, habilitation needs and behavioral needs) to designated provider staff, and another three called for those designated staff to train other specific provider staff. The final three supports required Abilene SSLC staff to then complete a competency check after all the training had been completed. In most respects, these supports represented a substantial improvement compared with those the IDT developed for Individual #391 months earlier and since the last monitoring visit. To continue to move toward compliance, the Center should continue to focus on defining specific competency criteria and ensuring the tools for measuring those competencies are thorough. Findings included:
  - All supports described the provider staff who needed to be trained and have a competency check completed.
  - All the supports provided a list of topics as the content to be covered under each broad area of training. A few of these topics indicated the specific knowledge staff would be required to know by the time of the transition, which was positive. For example, the support for medical and nursing needs listed gastroesophageal reflux disease (GERD) as a training topic and indicated staff needed to know Individual #447 should remain upright one hour after eating or receiving her medications and required an anti-reflux diet. Still, most did not describe an expectation for specific knowledge or competency. For example, habilitation training topics included hearing strategies, communication strategies, mealtime techniques, food textures, and liquid consistency. None of these provided any specific criteria by which competency could be measured.
  - All the supports stated a methodology for training. Most often, the supports for training required didactic/classroom training. It was good to see, though, that the IDT sometimes incorporated other training methodologies. For example, the training regarding her behavioral needs included actual interactions with Individual #447, and the training for transfers included actual participation in transferring from the wheelchair to toilet and back. The Monitoring Team commends the Center for these improvements and encourages IDTs to continue to consider when training techniques other than just didactic teaching would be more appropriate. For example, Individual #447 had a secondary transfer method requiring the use of a mechanical lift, for which hands-on demonstration would have been more likely to result in staff competence than verbal instruction.
  - All supports included a reference to how competency would be determined. Most often, it was to be determined by a written test, requiring a score of 100%. Overall, these written exams did not test competency as needed. Testing needed to be constructed to measure the specific criteria that would demonstrate staff were competent to provide supports as required. Because the IDT did not indicate the specific needed competencies (e.g. specifically what staff must know about hearing or communication strategies), the process was fundamentally flawed. In addition, the tests reviewed did not include questions for many of the topics listed as needed content under each support, so there was no evidence of related staff knowledge.
  - It was positive the Center developed pre-move supports to follow up on provider staff training to complete a competency check, particularly since the IDT did not directly train the provider's direct support staff. Even when the IDT chooses to delegate such training to the provider, it remains incumbent upon them to verify staff competence first-hand before transition takes place. The current process required the respective Center disciplines to check competencies by verbal and demonstration responses. Transition staff indicated they had

confidence in the potential of this process. For this to be effective, the Center will need at a minimum to ensure competency criteria are comprehensive and clearly stated and that all such criteria are tested according to the prescribed methodology.

- Post-Move: The respective IDTs developed 38 post-move supports for Individual #391 and 61 post-move supports for Individual #447. It was positive the IDTs consistently required more than one form of evidence to validate the presence of post-move supports. It was also positive the IDTs had continued and expanded the practice of providing specific criteria the PMM could use to determine if the support was in place as needed, which also could be used as a starting place for developing the competency criteria and testing for pre-move training. These practices contributed to the overall measurability of the post-move supports. To continue to move toward compliance, the Center should focus on clarifying the wording of supports to avoid terminology such as "as needed" and to ensure specific outcomes and frequencies are spelled out. For example, Individual #391's CLDP included post-move supports for all new provider staff to be trained, but stated no requirement regarding the outcome of competency. Another post-move support called for her to be referred to the audiologist as needed, but did not provide any detail about what the provider staff should watch for to determine that necessity.

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. Still, neither of these CLDPs fully and comprehensively addressed support needs and did not meet criterion, as described below.

- Past history, and recent and current behavioral and psychiatric problems: The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. To meet criterion, the IDTs should continue to make improvements in developing comprehensive supports that reflect both current needs and pertinent history. Findings included:
  - Per Individual #391's CLDP narrative, she had received both psychiatric and behavior support services in the relatively recent past. In March 2015, the IDT discontinued psychiatric services, but she had a history of being treated with various medications, including Tegretol, Haldol and Cogentin, as well as Ativan for sleep disturbance. In January 2016, the IDT discontinued her positive behavior support plan (PBSP) after she met criteria and showed continued stability off psychiatric medications. The PBSP had targeted the behaviors of self-injurious behavior, stripping, and inappropriate urination and defecation. Per her assessments and CLDP discussion, Individual #391 still displayed agitation at times that included hitting herself on the hips and face and biting her wrists. Per the CLDP narrative and assessments, home staff indicated she could be easily re-directed if she was allowed to be somewhere quiet and away from people. It was concerning that the IDT identified these behaviors as communicative in nature, but they had not identified any behavioral strategies toward more appropriate functional communication. The behavioral health assessment (BHA) made no recommendations for behavioral supports or provider staff training regarding her behavioral and psychiatric history or behavioral/communicative strategies to address agitation. The CLDP did not include any related supports.
  - For Individual #447, the CLDP included several good, detailed supports for addressing her current behavioral needs, which included aggression and problem-solving. This was very positive. To continue to move toward compliance, the IDT should develop supports that ensure staff knowledge of her behavioral and psychiatric history, which included withdrawal, sleep disturbance, self-injurious behavior, and depressive symptoms.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. To meet criteria, the IDTs still needed to develop clear and comprehensive supports in this area. For example:
  - Individual #391 had elevated risks in the areas of choking; osteoporosis, falls, and fractures; infections and skin integrity; and cardiac disease. The IDT did not develop assertive and comprehensive supports in any of these categories. For example:
    - For choking, the Integrated Risk Rating Form (IRRF) noted her medications were to be served crushed and mixed in pudding or in liquid form. However, per the quarterly drug regimen review (QDRR), one of her medications (Diamox) was not to be crushed, since it was a time-released capsule. As such, the IRRF noted the IDT needed to discuss safe administration of this medication. The CLDP supports indicated all medications were to be crushed except for the fish oil. It did not address the administration of the Diamox. As discussed on site, this might require follow-up with the provider.
    - In the area of osteoporosis, falls, and fractures, the IDT failed to correctly address the findings and recommendations of the most recent endocrinology report. Per the update to the annual medical assessment (AMA), the primary care physician (PCP) recommended following the endocrinologist's recommendations of 5/1/17, regarding osteoporosis, which called for a repeat DEXA scan in one year on the same machine as the most recent one and to have a follow-up appointment by April-May 2018 to re-check. As background, in 2016, the endocrinologist recommended holding her medication for osteoporosis (Prolia) for one year because she had been on it for a long time, and then re-checking at one year. At the time of the 2017 appointment, the endocrinologist stated the scans could not be compared because they were completed on different equipment. He again recommended holding the Prolia until the next re-check in 2018, as described above. The CLDP narrative indicated her Prolia had been discontinued because she showed improvement, but the available documentation in the AMA indicated only that the DEXA scan in 2016 showed a worsening of bone mass since the first in 2002. The CLDP support indicated that the provider would ensure a DEXA scan would be completed by April 2018, and an appointment scheduled with the endocrinologist to monitor osteoporosis by May 2018. It did not provide any detail about the need for the DEXA scan to be completed with the same equipment. As discussed on site, this might require follow-up with the provider.
    - In the area of skin integrity, Individual #391 had potential for skin integrity compromise and Center direct support staff were to monitor her skin daily during bathing and report to the nurse any skin breaks/red areas/ bruises swelling/open/draining areas. The CLDP did not include any related supports.
    - Individual #391 had elevated cardiac risk due to hyperlipidemia and glaucoma treated with routine medications, and diagnoses of congenital heart disease and heart murmur. Per her IRRF, direct support professionals were to notify nursing staff of any chest pain, sweating, skin color changes such as blue or purple, or of any deep vein thrombosis (DVT) symptoms such as localized swelling (or any swelling), and/or warmth or skin color changes in lower extremities, such as redness or bluish tint. Per the Integrated Health Care Plan (IHCP), nursing staff was to complete a monthly assessment of signs and symptoms. The CLDP did not include any monitoring supports.
    - The Monitoring Team was also concerned about the failure to identify assertive and comprehensive support needs related to hearing, orientation and mobility, and weight.

- Individual #447 had elevated risks in choking; respiratory compromise/aspiration; gastrointestinal; cardiac; osteoporosis, falls, and fractures; infections/skin integrity; and medications side effects/interactions. Overall, the IDT developed many detailed and thorough supports for her needs in this area. This was positive. To achieve compliance, the IDT should have developed a support describing her specific needs for supervision, as well as supports that described her needs for ongoing nursing oversight, and OT/PT monitoring to address her many risk areas and habilitation needs.

- What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Neither CLDP assertively addressed these outcomes. Findings included:
  - Individual #391's CLDP indicated her important outcomes included living in a smaller/quieter home environment per her preference; having her own room where she could nap or go to be alone; to increase her independence with activities of daily living (ADLs); and, to access the community regularly and identify new activities of interest to her. The transition addressed the first two outcomes, but the IDT did not develop assertive supports for the latter two. One support did call for the provider to implement skill training for applying lotion and/or using a napkin, both of which had been implemented at the Center. Otherwise, the support stated other training may be implemented as indicated after transition. As written, this support would be met by implementing one skill acquisition program, which was less than she had at the Center. This would not satisfy the intent of increasing her independence with ADLs. The CLDP included only one support related to community access and identification of new activities of interest: to have the opportunity to participate in outings at least once a week with additional outings if she showed an interest in other offered activities.
  - For Individual #447, the CLDP identified important outcomes as increasing her independence with ADLs, to maintain contact with her friend and friend's family, to stay busy with a variety of activities and outings, and to have her own personal space that she does not have to share with others. The IDT developed some supports for these outcomes, but did not take an assertive approach to what was important to her. For example, her most important relationships were with her friend and the friend's family, who thought of Individual #447 as a part of the family. The only support was a broad one, for staff to assist her to maintain contact by helping her to make phone calls and set up visits. In addition, the ISP and PSI identified other things that were important to her, including active church membership and volunteering in the community. At the Center, she was actively involved in the Aktion Club, a volunteer organization connected to the Kiwanis Club in the community. It would have been good to see the Center develop supports for such activities in the community.
- Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion, as described below:
  - Individual #391's IDT developed a support for her to attend a day habilitation program in the morning and then return home for lunch and a nap, followed by in-home activities. Overall, this support matched Individual #391's preferences for routine. The Monitoring Team noted PMM documentation that indicated the provider engaged in many community activities during the afternoons, which was positive and could provide the IDT with some additional perspective on how to craft a support that included meaningful day activities.
  - All the documentation (ISP, assessments, PSI) made available for review indicated employment and earning income was very important to Individual #447 and that she preferred this to most other activities. Her ISP goal had been to

obtain a job in the community. The CLDP indicated Individual #447 reported at the 14-day meeting in May 2017 that she was ready to retire from working and wanted to attend a day program. The 14-day ISPA did document that Individual #447 stated this preference; while the 14-day documentation was thorough in many respects, it did not reference any vocational or day programming information in the description of supports and services being provided at that time. It was concerning the IDT did not explore this more assertively. Transition staff reported Individual #447 was happy in her day program environment, which was positive. Still they also stated the IDT had been surprised by this sudden shift in Individual #447's attitude towards work and that she was known to change her mind frequently about many things; as such, the IDT should have at least crafted a support for the provider to monitor her preferences in this regard and perhaps make opportunities for work exploration available.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined supports that included some elements of positive reinforcement and other motivating components.
    - For Individual #391, the IDT developed supports to ensure she had access to her preferred chair and keyboard, which had been identified as things that she enjoyed. The IDT should have also considered how it might have used positive reinforcement or incentives to address agitation.
    - For Individual #447, the IDT developed an assertive support describing strategies for positive reinforcement and motivation. The CLDP also included a support for implementing her replacement behavior. This CLDP met criterion.
- Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs did not develop assertive supports related to teaching, maintenance, participation, and acquisition of specific skills.
    - As described above, Individual #391's CLDP did not assertively address skill acquisition.
    - For Individual #447, the IDT did develop a support to learn new skills of using the telephone and doing her own laundry, which were her preferences. This was positive. On the other hand, the IDT did not develop supports for money management. The IDT developed a support for the provider to become representative payee, assisting her with budgeting and bill paying. Her ISP included a skill acquisition plan (SAP) to sign her checks and deposit money, which would have been very appropriate for promoting her increased community independence in this area.
- All recommendations from assessments are included, or if not, there is a rationale provided: Overall, Abilene SSLC had a process in place for documenting discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional recommendations. As described in examples above, the IDT did not consistently address recommendations with supports or otherwise provide a justification.
    - For Individual #391, the IDT did not address all recommendations or provide the necessary justification, such as for the previously-described recommendations regarding the specific needs for follow-up DEXA scan or the crushing of her medication. Other concerns in this area included:
        - The nutrition assessment recommended monitoring Individual #391's weight at least monthly, indicating her weight had been stable for several years. It further stated if she should start to have trouble with her weight being below or above her recommended weight range, the community PCP could refer her to a dietitian for an evaluation. The support called only for a monthly weight, but did not provide any parameters by which the provider should consider an evaluation. This was of concern, as Individual #391, at a current weight of 103 pounds, had a 4.5-pound unplanned weight loss in the last year and was on a downward trend, albeit a slow one.
        - The residential assessment recommended a Velcro strip or trail for her to locate areas in her new home, which

could help her become more adjusted more quickly. Per the CLDP discussion, the IDT decided not to include any supports for this, or for having something outside the bathroom to help her identify it, which she had at the Center, because the provider said Individual #391 seemed to be adjusting to getting around the house during her preplacement visits. The IDT had not verified this. They should have provided some detailed rationale as to why this would not have been beneficial and carried over from the Center.

- For Individual #447, the IDT consistently addressed recommendations from assessments and provided justifications for any modifications.

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

Summary: Given that over the last two review periods and during this review, for the individuals reviewed, the Post-Move Monitor conducted timely monitoring (Round 11 – 100%, Round 12 – 100%, and Round 13 – 100%), Indicator 3 will move to the category requiring less oversight. Although the Post-Move Monitor generally paid good attention to detail, some of the areas in which continued efforts were needed related to the PMM consistently basing decisions about supports on reliable and valid data, the PMM correctly scoring the presence or absence supports based on the evidence, and IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports. The remaining indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	391	447							
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.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							

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

Comments: 3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes, were done in the proper format and occurred at all locations where the individual lived or worked. As reported at the time of the last monitoring visit, the Monitoring Team found the work of the PMM to be commendable for its thoroughness and attention to detail.

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 substantial comments. These typically addressed the required evidence, but there remained a few instances when this did not occur. For example, Individual #391 had a post-move support to receive a low cholesterol diet that should provide a daily average of 2200 calories. The PMM consistently evaluated whether a low cholesterol diet was being provided, but did not address caloric requirements at any of the four PMM visits. 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 in 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, both individuals frequently had received supports as listed and/or described in the CLDP, but this was not yet consistent. As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack clarity and measurability in the supports as written. Examples of important supports not in place as required included the following:

- For Individual #391:
  - At the time of the 45-day PMM visit, day program staff did not have knowledge of the following supports: to monitor and document bowel movements daily due to a history of constipation, dietary needs, mealtime plan, and assistive equipment. The day program also did not have her equipment available.
  - At the time of the 45-day and 90-day PMM visits, the provider did not adhere to Individual #391's dietary requirements. At the 45-day PMM visit, lunch served at the home consisted of fried fish, which was not appropriate for a low-cholesterol diet. At the 90-day PMM visit, the PMM observed that the snack sent to the day program for Individual #391 was not ground texture, but rather consisted of a sandwich and granola bar.
  - At the time of the 90-day PMM visit, the day program had not kept the bowel movement log and staff there were not familiar with her mealtime set-up. The foot stool for dining was not available.
  - At the time of the 90-day PMM visit, the provider had not trained new staff to competency.
  - At the time of the 180-day PMM visit, the provider had not obtained the colonoscopy as required.
- For Individual #447, most supports were in place at the time of the seven-day PMM visit. For one support requiring an anti-reflux diet, the PMM accurately identified the provider sent the day program a lunch meal for Individual #447 that did not comply with anti-reflux requirements. Another support called for the provider to monitor Individual #447's blood pressure on a monthly basis and to report to the nurse if it exceeded 140/90. Per the PMM Checklist, the PMM interviewed the provider nurse about this support. The nurse stated she had taken Individual #447's blood pressure on the day she transitioned and the reading was 158/96. She further indicated this might be due to excitement about the move and that she would continue to take

Individual #447's blood pressure monthly. This was concerning. The provider nurse should have at least documented re-taking the blood pressure, a standard practice under such circumstances. Per the IRRF, Individual #447 was at high risk for cardiac disease. It further indicated she was to have a blood pressure taken daily before medication administration, but the CLDP did not include this information in any support, nor was it specifically covered in the nurse-to-nurse training. As discussed during the onsite review, the Center should notify the provider of the need to correct this discrepancy.

6. The Post-Move Monitor's scoring was often correct, based on the supports defined in the CLDP. The Monitoring Team identified some discrepancies, including the issue related to Individual #447's blood pressure support described immediately above, which was significant. This support should have been marked as not in place, or at least referred to the IDT for follow-up.

In addition, the PMM marked a support for Individual #391 as in place that was not. The support called for home and day program staff to report to the nurse any falls, bruises, or redness, and for the nurse to assess and recommend needed treatment. At the time of the 45-day PMM visit on 8/29/17, the PMM documented the provider staff reported both a bruise and several scratches to the nurse, who had provided instructions for treatment and/or monitoring. The evidence provided indicated provider staff had not used the prescribed process to also notify the provider nurse of a recurrent red spot or obtain recommendations for treatment and/or monitoring. The provider home staff did report this to the PMM, including their estimation this was due to her sleeping position. The PMM brought the issue before the IDT for their input, which was an appropriate action, but did not highlight the lack of evidence to show that the provider nurse had been notified and/or that the nurse was monitoring the red spot. The IDT failed to ask if the provider nurse was monitoring or recommend any additional monitoring. Per the documentation from the initial PCP visit on 8/30/17, the physician diagnosed a pressure ulcer in that area.

7. through 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. Once a need was identified, the PMM was extremely diligent in following up to ensure corrective actions were implemented in a timely manner. It was also positive the IDTs met to review the PMM Checklists and make recommendations for any unmet supports, and that the PMM documented the required follow-up had been completed. The Center had made additional improvements to its processes for ensuring follow-up, including sending the completed PMM Checklists to the provider and LIDDA. As reported at the time of the last monitoring visit, the Monitoring Team found this continued to be an area of strength in the Center's transition processes. Still, some follow-up needs were missed, such as the need to follow-up on the elevated blood pressure for Individual #447 described above. The most significant gap in ensuring needed follow-up occurred at the time of the 90-day PMM visit for Individual #391. At that time, the PMM obtained the consultation documentation of her initial visit to the community PCP. This documentation revealed a number of potential concerns the IDT should have identified and addressed, but did not. For example:

- At the time of the 45–day PMM visit, provider staff reported Individual #391 would often wake in the morning with a red spot on her shoulder, which they attributed to her sleeping position. They reported this to the PMM, who in turn questioned the IDT about whether that was her typical sleeping position. The IDT indicated it was and the matter was considered resolved. A review of the PCP consult indicated he had diagnosed a pressure ulcer of unspecified stage, prescribed venelex to be applied topically, and indicated she needed to start using a protective pad while in bed to avoid a deeper lesion. It was not clear whether the PMM or IDT reviewed the consult carefully, but the Center did not provide any evidence these concerns had been identified or addressed.

- The consult also stated her oxygen saturation level was 79% at rest. The IDT should have identified this as a need for follow-up based on her cardiac risks.
- The PCP documented the patient and caregiver were poor historians. This should have prompted follow-up to be ensure the community PCP had the needed medical history. For example, the consult indicated she had no known allergies, but she was allergic to Propine eye drops.
- At the time of the consult, on 8/30/17, Individual #391's weight was documented as 100.2 pounds, which was a weight loss of about three pounds since her transition. The PCP indicated her general appearance was "too thin." This should have prompted the IDT to follow-up on her weight loss, especially to ensure the post-move support adequately informed the provider of the need for additional consultation. By the time of the 180-day, Individual #391's weight had dropped further to 98 pounds, and as low as 96 pounds on 12/6/17, without any follow-up.
- The consult indicated the PCP was not fully aware of her diagnosis of hearing impairment. He stated the caregiver said Individual #391 seemed to be having trouble hearing recently, but that he could not ascertain due to her lack of responsiveness. It was positive, though, that he referred Individual #447 to the audiologist and an auditory brainstem response test was pending.

9. through 10. During the onsite review week, no post-move monitoring visits occurred.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.											
Summary: Neither individual reviewed had experienced a PDCT event.			Individuals:								
#	Indicator	Overall Score	391	447							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1							
Comments: 11. Neither individual reviewed had experienced a PDCT event.											

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: It was positive transition staff had been working with several disciplines on the quality of transition assessments and recommendations, and some improvement was observed. There remained a need, however, with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. It was positive that IDT members participated in transition planning, and that the individuals and/or guardians were involved and kept up-to-date on the	Individuals:

decision-making. The CLDPs included numerous pre-move supports for pre-move training, which was a good improvement, but these did not yet fully meet criterion for ensuring that provider staff were competent for either individual reviewed. These indicators will remain in active oversight.

#	Indicator	Overall Score	391	447							
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.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	50% 1/2	0/1	1/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments: 12. Assessments did not consistently meet criterion for this indicator. It was positive transition staff had been working with several disciplines on the quality of transition assessments and recommendations, and some improvement was observed. This remained an area of need, however. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated within 45 Days of transition: Assessments provided for review consistently met criterion for timeliness, but the Center did not yet consistently provide all needed updated assessments.
  - It was positive the IDT for Individual #447 obtained and reviewed the QDRR during the CLDP meeting. It likewise documented that the IDT updated and reviewed the IRRF.
  - The IDT for Individual #391 did not provide an updated IRRF. It did obtain a recent QDDR, but should have documented its review in the CLDP. If the IDT had reviewed the QDRR, it likely would have prompted them to address the issue related to the need to not crush the Diamox, as described with regard to Indicator 2 above.
  - The IDT did not provide an updated audiology assessment for Individual #391, but should have. Per the ISP on 5/5/17, home staff at Abilene SSLC reported she sometimes responded to her name and to other sounds such as music, and the IDT agreed her hearing needed to be re-evaluated. The documentation did not provide evidence this had been completed. The Center's SLP completed the audiology update, who stated she presented auditory stimuli an inch from Individual #391's ear and did not obtain a response. She then indicated the most recent audiology exam from 11/9/16 had been reviewed and compared to her current status, but this did not reflect the current recommendation from the ISP.
  - The IDT did not obtain an updated comprehensive occupational and physical therapy (OT/PT) assessment for Individual #391. The Center last completed a comprehensive assessment on 6/25/12. Habilitation staff indicated she did not need a new comprehensive assessment, because there had been no functional changes, although interim addenda indicated otherwise. Habilitation staff should have completed a comprehensive assessment, taking into account her new environments and potential needs for orientation and mobility supports.
- Assessments provided a summary of relevant facts of the individual's stay at the Center: Assessments did not consistently meet criterion. For Individual #391, these included the OT/PT assessment as indicated above. Overall, Individual #447's assessments provided more thorough and relevant summaries.
- 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 yet thoroughly provide recommendations to support transition. These included the OT/PT and behavioral health assessments for Individual #391, and the psychiatric assessment for Individual #447. Overall, Individual #447's assessments demonstrated improvement in this area, but still did not consistently provide specific comprehensive recommendations that could be used to develop measurable competency criteria and measurable supports.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Currently, assessments did not consistently meet criterion in this area.

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

participation.

14. Center staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: To achieve compliance, the Center must describe how it will verify that provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. The Center had made some improvements to its training processes for community provider staff, but did not yet meet criterion for these two CLDPs. Findings included:

- The Center had made some progress in describing the needed content of training for each individual, but this was not yet consistent.
- It was also positive the IDT for Individual #447 had considered some training and competency testing methodologies that went beyond classroom style training to be included, such as hands-on demonstration.
- The IDTs still needed to consistently develop specific competency criteria to guide the training and testing. As described regarding Indicator 1, the IDT did not develop written exams that tested competency as needed. To continue to move toward compliance, the Center should ensure its written exams are constructed to cover all essential knowledge. The testing materials the Monitoring Team reviewed fell short of this mark. Competency testing did not clearly document provider staff had the knowledge of all essential supports based on individuals' needs. Most competency quizzes probed only a very small number of the many specific needs and supports for each individual.

15. When necessary, Center staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any was completed, summarize findings and outcomes. For these two transitions, the Center did not yet use the updated CLDP template that includes a prompt for this indicator. Neither CLDP indicated whether it discussed the need for any such collaboration, and they did not include any related supports. As described above, the lack of needed medical history available to Individual #391's PCP highlighted the importance of making this consideration.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. Again, for these two transitions, the Center did not yet use the updated CLDP template that included a prompt for this indicator, but did document some consideration of these needs in the Summary of Transition Activities.

- For Individual #391, the IDT documented the OT completed a tour of the home prior to the pre-placement visit. This was positive, but given Individual #391's significant sensory impairments and her use of environmental prompts for orientation and mobility at the Center, the IDT should have considered whether Center staff needed to observe while she was in the home and at the day program site.
- For Individual #447, the Habilitation Technician completed observations of both the home and day program to verify the presence and adequacy of the needed equipment. This was positive and met criterion.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities that SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results.

Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. The IDTs did not document this consideration.

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

19. The PMSRs for both individuals were completed prior to the transition date. It is essential the Center directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility. The Center made progress in this area, but neither of these two PMSRs fully accomplished this. Findings included:

- It was positive the PMM provided comments about the evidence relied upon to verify each support was in place.
- The PMM relied upon implementation of pre-move training supports to confirm provider staff were prepared to implement supports as needed. As described above regarding Indicator 1 and Indicator 14, the CLDPs included numerous pre-move supports for pre-move training, but these did not yet fully meet criterion for ensuring that provider staff were competent for either individual.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	391	447							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 2/2	1/1	1/1							

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

- Individual #391 was referred on 5/26/16, and transitioned on 7/20/17. This exceeded 180 days, but the transition log documented ongoing effort by the Center and provided justifications for unanticipated delays. The IDT also made a conscious decision it wanted to move slowly in the transition process, because a previous referral had not progressed as planned. The IDT planned for three overnight pre-placement visits to ensure Individual #391 was comfortable in the new environment. This was a positive practice.
- Individual #447 was referred on 5/6/17, and transitioned on 2/3/18. This exceeded 180 days, primarily because Individual #447 had made a choice of a home that did not have a current opening. The IDT documented offering her other options, but she clearly made the decision to wait for an opening to occur.

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 <u>or</u> 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